Library

of the

Academy of Medicine,

Toronto.

Presented by

Dr. N. A. Powell.

Presented to the
ONTARIO Medical
Library Toronto.

THE

Gowell

MEDICAL AND SURGICAL REPORTER:

A WEEKLY JOURNAL.

(ESTABLISHED IN 1858, BY S. W. BUTLER, M. D.)

EDITED BY

D. G. BRINTON, M. D.

JULY—DECEMBER, 1880.

VOL. XLIII.

PHILADELPHIA:
No. 115 SOUTH SEVENTH STREET.
1880.

4539

CONTRIBUTORS.

ALVERSON, J. C., 416.
ASHHURST, JOHN, Jr., 142 470.
ATKINSON, Wm. B., 50, 111, 155, 485.

BARBER, JOHN, 285.
BATTEN, J. M., 415, 536.
BIGELOW, H. R., 147, 209, 333, 46[illegible].
BLACK, J. R., 381.
BLACKWELL, E. T., 289, 355, 464.
BLACKWOOD, W. R. D., 91, 219, 3[illegible]6.
BROCKMAN, D. C., 460.
BROADMEADOW, E., 220.
BOYLAND, G. H., 6, 243.
BURD, EDWIN, 445.
BURR, H. N., 265.
BYRD, W. A., 507.

CARPENTER, E. G., 174.
COLLINS, L. J., 547.
COOMES, M. F., 73, 353.
CORDELL, E. F., *Report*, 537.
CRANDALL, C. R., *Report*, 10, 291.
CRAWFORD, J. L., 434.
CROTHERS, T. D., 257.

DAKE, J. P., 109.
DALY, W. H., 71.
DANIELLS, J. E., 219.
DELAFIELD, F., 529.
DULLES, C. W., *Report*, 142.

ENGEL, HUGO, 67, 421.
E. T., 446.

FARNSWORTH, P. J., 482.
FLINT, A., 426.
FRIEBIS, Geo., *Report*, 331.
FORWOOD, W. S., 23, 31.
FOX, G. P., 19.

GOODELL, Wm. 208.
GROSS, Prof., 242.
GRUBB, I. N., 526.

H. C. P., 525.
HEILMAN, J. G., 534.
HERBST, H. H., 174
HICKMAN, J. W., 424.
HOLMAN, W. J., 284.
HOLT, J. P., *Report*, 57.
HORTON, HENRY L., 393.
HUTCHINSON, JAS. H., 513.
HURD, E. P., 328.

IFILL, E. P., 130.

JACOBI, Prof., 30, 336.

KELCH, A. H., *Report*, 73, 120, 353, 419, 496, 515.
KEYSER, P. D., 27.

LANDESBERG, M., 248, 397.
LANGWORTHY, O. P., 65.
LEEDOM, OSCAR, 284.
LEONARD, C. H., 5[illegible]5.
LEVIS, R. J., 463.
LOWER, M. O., 96.

MANLEY, T. H., 159.
MARSH, F. L., 512.
MASON, G. W., 164.
McCONAUGHEY, ROBERT, 350.
MERRICK, O. H., 196.
MIZENER, J. L., 394.
"MONROVIUS," 108.
MONTGOMERY, E. E., 375.
MORRISON, W. H., *Report*, 1, 45, 89, 98, 133, 177, 208, 470.
MORTON, T. G. 537.

NUNN, R. J., 87.
NYE, H., 20.

O'CALLAGHAN, JOHN F., 439.
OLIVER, Chas. A., 199.
OLIVER, Geo. P., 309.
OTIS, FESSENDEN N., 184, 491.

PANCOAST, Wm H., 331.
PARRISH, JOSEPH, 568.
PEPPER, Wm., 1, 45, 89, 133, 177.
PETERS, SAMUEL, 221.
POLK, W. M., 272.
POLLOCK, S. D. 306.
PURSELL, H., 557.

RAFFENSPERGER, E. B., 489.
REBER, Chas. T., 152.
REED, BOARDMAN. 525.
ROBINS, JOSEPH, 378.
ROBERTS, JOHN B., 203, 356.
RULISON, E. T., 483.
RUSK, G. GLANVILLE, 400.

SAJOUS, Chas. E., 398.
SHELL, H. S., 53.
SEGUIN, E C., 197.
SEILER, CARL, 290.
SEIP, W. H., 19.
SHIVERS, C. H., 372.
SNIVELY, I. N., 416.
SNOWDEN, JOHN W., 242.
SOUWERS, G. F., 447, 513, 557.
SOZINSKEY, T. S., 2[illegible]6.
STERLING, G. A., 395
STEWART, EDWIN, 131.
STEWART, F. E., 140, 465.
STIMPSON, A. O., 175
STINSON, J. E., 306, 350.
STRAWN, E. K., 482.
STROUT, A. O., 226, 425.
SUTTON, R. S., 43, 441.

TODD, W. C., 175.
THOMSON, W. H., 314, 381, 401.
THOMPSON, J. H., 439.
TUCKERMAN, L. B., 262.
TURNBULL, L., 172, 250, 510.

VANCE, R. A., 138.
VANDERBECK, C. C., 161.
VAN VALZAH, W. W., 10, 291.

WARD, S. H., 154.
WATHEN, W. H., 419.
WIGHT, J. S., 141, 270, 442.
WILSON, H. AUGUSTUS, 114, 468.
WILSON, W. G., 415.

LIBRARY
DEC 1 9 2001
UNIVERSITY OF TORONTO

THE

MEDICAL AND SURGICAL REPORTER.

No. 1218.] PHILADELPHIA, JULY 3, 1880. [Vol. XLIII.—No. 1.

Original Department.

Lecture.

III. PULMONARY PHTHISIS.

Delivered at the Philadelphia Hospital, December 3d, 1879,

BY WM. PEPPER, M.D.,

One of the Physicians to the Hospital, and Professor of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WM. H. MORRISON, M.D.

Gentlemen:—Last Wednesday I tried to indicate to you the different forms of chronic pulmonary disease which we most frequently meet; at what stage we are to regard them as coming under the head of phthisis; the different forms of phthisis, and their relation to tuberculosis of the lung.

Now, before examining individual cases of these different types, I will consider briefly the causes of pulmonary phthisis. On approaching this subject there are one or two questions which at once confront us. Why is it that one persons gets pulmonary phthisis after the most trifling cold, while another may have many and severe attacks without developing phthisis? Why is it that one, after a short duration of phthisis, gets tuberculosis of the lung and dies rapidly, while another, with a much more serious phthisis, lives for many years in comparative health, or else gets entirely well?

First, why is it that some get phthisis after slight attacks of pulmonary trouble? The popular answer is, at once, that they have inherited a tendency to consumption. Undoubtedly we must recognize the fact that the reason one man may have a catarrhal or croupous pneumonia and get well quickly, while another runs into a state of chronic phthisis, is partly owing to some peculiarity of the person himself, some constitutional tendency.

No one now believes that tuberculosis is inherited. Such a thing is impossible. The only thing that can be inherited is a tendency to phthisis, some peculiarity of anatomical structure or vital activity, that predisposes the individual in one or other direction. This may easily be inherited. When you remember that pulmonary phthisis destroys, taking the whole world over, one out of every five adults who die, or, perhaps, one out of every six, you can easily understand that few of us can look back upon our family history without finding some relative who has died of chronic lung disease. Take, for instance, a family of four or five children; one of these gets phthisis, and we will say that the parents and grandparents are dead; now here you have at least six persons, and it is quite likely that one of these has died of phthisis. But you may go still further, and inquire if the uncles and aunts are living; you see that you now have, perhaps, twelve or thirteen persons, and the general probabilities of disease, as the world is at present, are such that it is very likely that at least one out of this number has perished from phthisis. If you examine statistics you will find that they take into consideration, in addition, the cousins, brothers and sisters; there will thus be brought into the circle of inquiry a score or more of individuals subject to the ordinary laws of disease, and when you remember that on an average one out of every five or six dies of phthisis, in all classes and under all conditions, you will easily understand that in almost every family you will be pretty sure to come across some who have had phthisis.

Now, do such facts show any inherited disease? I think not. Unless we can find that either of the parents, previous to the conception or birth of that child, had exhibited distinct evidences of constitutional weakness, or a tendency to lung trouble, I do not think that we should say that the child had inherited its tendency from the parents. Again, every one of us is liable to become the subject of some acute attack which may pass into phthisis; so that if, after the child is born, one of the parents gets a chronic pneumonia, which passes into phthisis, that is no proof that the child will have phthisis; but if the parent, before the birth of the child, had exhibited signs of phthisis, it is probable that the child will have a similar tendency; or, if the parents are fairly well, but several of the children show marked constitutional weakness, and a tendency to lung trouble, we must say, although we cannot exactly see how it is, that they have begotten children of a weak constitution, with a tendency to pulmonary phthisis.

I want to rid you of the idea that pulmonary phthisis occurs principally in those who may be said to have an inherited tendency to it. Indeed, I do not think that you will be able to demonstrate such a tendency in more than one-half or one-third of your cases. If such a fallacy is allowed to exist, and a person feels that because there is no phthisis in his family he can expose himself to cold, damp, and other depressing causes without risk, there is the greatest possible danger that he will contract phthisis, for we know that at least in one-half or two-thirds of all cases of phthisis it is an acquired disease in those that have had no inherited predisposition to it. Everybody is liable to phthisis; some more so than others. Unquestionably, those are more liable to it who are born of parents of a weak constitution, especially if this has shown itself before the birth of the child, by a tendency to lung trouble, or if they have begotten other children with a tendency to phthisis. But it is not only an inherited predisposition that makes one more liable to phthisis than another. Any inherited delicacy of constitution, anything that makes the person more liable to be affected by depressing causes, anything, in short, that diminishes the vitality of the individual or his hold upon life, and tends to keep up an unhealthy type of physical action, all these are predisposing causes of phthisis. It is thus that such causes as starvation, bad food, bad hygienic surroundings, long nursing or improper food, impairing the primary assimilation during the period of development, act in a most powerful way in developing a weakness of constitution which may show itself later in a tendency to phthisis; so that a child may come into the world with this taint, or it may be developed during childhood by the causes I have mentioned; and, gentlemen, there is no time in the whole period of life when the causes that operate upon us to determine our future for good or for ill act so powerfully as during this period of childhood. A neglected catarrh, an untreated diarrhœa, may so act upon the system as to bring about this weakness of constitution. If we grasp this idea, it will lead us to infinitely greater carefulness in the hygiene and treatment of young children. The prophylaxis of phthisis you will find begins at birth, and the most important time for prophylactic treatment is during infancy.

But it is not only those who get the tendency by birth, or soon after birth, who are subject to phthisis. Many other causes tend to develop this susceptibility. Among these are various unhealthy occupations. Those that are sedentary, and keep the person in heated rooms, without proper ventilation, particularly if associated with the inhalation of irritating particles; occupations that involve the exclusion of sunlight; all these are predisposing causes. Depressing passions of every character, and excessive mental application, also act injuriously; but nothing, I think, predisposes more to phthisis than loss of sleep. A person who habitually gets insufficient sleep becomes so run down that any acute attack is very apt to run into a chronic form. Defective nutrition or insufficient food will also predispose to phthisis. Sexual excesses, particularly if they occur in persons whose constitution is somewhat depressed, from any reason, are a very fruitful cause of phthisis. I allude now to this as a fact bearing upon the prophylaxis, and any one in whom there is a slight tendency should be very careful how they expose themselves. This applies to both sexes. I have seen a person in whom there was a slight taint develop this disease within one year after marriage.

I cannot spend more time in going over these predisposing causes, but you see that they are all such as lower the nutritive power of the individual. Grouping them together, we recognize at once certain general conditions: first, an inherited defective vitality; second, an acquired sensitiveness of the system. This is shown in many individuals by a want of tone of the circulation, and diminished activity of the skin. Such people are exceedingly liable to take cold on slight

causes; now it is a cold in the head, now a sore throat, or again a slight muscular rheumatism. You find that such people do not react promptly under depressing causes. You find, as a rule, that the circulation in the extremities is defective, and a clammy condition of the skin. Third, a defective primary assimilation. In these people the digestion is easily disordered; now they have a loss of appetite, now a little diarrhœa, or again a slight gastric disturbance. They lose flesh from slight causes. With this there is apt to be a tendency to become feverish from trifling causes.

Now, if any of these conditions exist in a person, or if he has from childhood shown a feeble hold upon life, so that he has never been strong, and has grown up thin and lank, you will have a person predisposed to phthisis; and here we have the reason why, if that person gets croupous or catarrhal pneumonia, instead of throwing it off in a short time, and the cells of the part returning to a healthy mode of action, it passes into a chronic state, and thus the disease will tend to become implanted and pass into a chronic destructive form.

This, you see, is very different from simply saying that they have an inherited tendency. I have told you that at least in one-half of the cases phthisis is an acquired disease, and it is in our power to remedy or remove many of the predisposing causes. Sometimes the tendency is so marked that it takes but a slight cold to start the disease, while in others the tendency is so slight that it may require many attacks to set on foot the destructive inflammation.

Now, in the second place, why is it that some, after they get phthisis, remain for a number of years without developing tubercle, while others get tubercle on the slightest provocation? This question is more difficult to answer. This tendency to have tuberculosis seems to me to be due to inherited individual peculiarities. I have already told you what we mean by tuberculosis: that it consists in an infection, either of an organ or of the entire system, in which infection there are produced special new growths of a lymphoid character which are destructive in their tendency, so that when this infection is once set up it usually runs on to a fatal issue. Some pathologists have gone so far as to say that it is impossible to have tubercle unless there is in the body some centre of cheesy degeneration. This centre may be a syphilitic gumma, a nodule of catarrhal pneumonia, an old abscess. It makes no difference what is the origin of this centre; it is only necessary that this matter is undergoing chemical changes of a septic character, and the liquid is being absorbed into the blood vessels, and carried first into the surrounding tissue and then into the whole body. This view is unquestionably too exclusive; for instance, I have seen such a case as this: a child whose parents were living at the time, but whose father had presented marked evidence of constitutional weakness, with a tendency to lung trouble previous to the birth of the child, so that on several occasions I had been compelled to send him on a sea voyage for the benefit of his health, and who died three years after the child, of tubercular phthisis. This child, while in apparently good health, suddenly breaks out with miliary tubercules of the membranes of the brain, of the lungs, of the liver, of the spleen, of the kidney, of the peritoneum, of the intestinal mucous membrane, of the bones and of the retina, but in whom, at the autopsy, conducted by myself, in which every tissue was examined for cheesy centres, not one was found. This example shows that the statement made by many German pathologists is not correct, for it is possible that a child may have such a virulent tendency to miliary tuberculosis that the disease may be developed by the slightest exciting cause; but such cases are exceedingly rare. Whenever such a condition exists, it usually shows itself in early childhood. Undoubtedly, in the majority of cases, there is a centre of infective inflammation, particularly characterized by the inflammatory products passing into a state of cheesy degeneration, and tuberculosis is generated in consequence of the absorption from this centre of some septic matter.

The reason why one person may have such a centre of degenerating inflammatory product for months or years without developing tuberculosis, while another will not have it a fortnight without becoming infected, must be due to one of two things. Either the matter, in one case, must be far more infectious—but it is very hard to see why this should be, for you can find no difference in the character of the sputa when examined under the microscope, and there is no difference in the general symptoms in either case—or it is due, as I think more probable, to the constitution of the patient.

The absorption of these matters is either by the veins or by the lymphatics. We know that some persons are much more susceptible to certain vegetable and animal poisons than others. Just as we have this susceptibility in regard to vegetable and animal poisons, it is possible that we may have a similar susceptibility in some individuals to be infected by these cheesy centres

in the body. This may depend partly upon the power of the lymphatics in one case to eliminate the poison from the system, while in others, instead of the lymphatics passing it rapidly out of the body, the poison sets up a slow inflammation which serves to multiply and increase the poison. This may be connected with some inherited anatomical peculiarity. We may find in the lungs of those who are very susceptible to this poison, that there is a special development of the lymphatic system, or we may find that the lymphatics are unusually patulous. If it is not this, it is some peculiarity in the vital activity of the part or of the individual; that is, if it is not structural, it is functional. Therefore, I say that the reason why one person becomes tuberculous after a cheesy nodule has existed a certain time, while another does not, seems to me to depend not so much upon any change in the lung, as it does upon some individual peculiarity which makes his system exceedingly liable to septic poisoning. I believe that this tendency to tuberculosis is very often inherited. In some cases it is so virulent that it may, as in the case of the child I have alluded to, break out without any apparent cause.

Let us now turn to a consideration of the cases before us. As I have told you we have different forms of phthisis. We will first study croupous phthisis, of which we have good illustrations in these two colored men.

This man has had croupous pneumonia since May. There has been marked solidification of the upper and lower lobes, posteriorly, of the right lung. After the ordinary course of pneumonia had passed, this man's defective nutrition showed itself in the fact that the lung did not clear up, but the consolidation remained. He presented a continued febrile action; progressive emaciation; the sputa continued to be purulent, large and heavy; the râles, which, during the third stage, as the exudation became soft, were large and moist, continued so, and blowing respiration was also heard.

He came into the hospital in this condition. The croupous pneumonia had become a chronic pneumonia. It had become so either from the extreme violence of the attack, or from the defective vitality of the individual. When he was admitted it was a question whether this man would run into a croupous phthisis, or whether the lung would clear up. I am happy to say that the greater part of this exudation has been absorbed. I can find only one spot where there is evidence of destruction of lung tissue. In this man, then, where there is a clear family history and good previous health, the acute attack of pneumonia, his nutrition being so good, does not seem to have led to any very serious phthisis, and the man is getting well.

In this other man, Taylor, there was a croupous pneumonia of the lower lobe of the left lung. When I first saw him it was in a state of solidification. There was flatness on percussion from the spine, following the curve of the left lower lobe around to the front, and over this area there was tubular breathing. The expectoration was purulent, with large, solid, nummular sputa. He had febrile action every day, of a hectic type, sweating at nights, and had undergone a moderate degree of emaciation.

In the colored race there is an unusual tendency for pulmonary diseases to become chronic and run into phthisis. This is especially true where they live in cold climates, but it is not nearly as true of the full-blooded African, as it is of the dilution of the colored race with white blood. The tendency of this latter class to phthisis from the slightest causes is recognized everywhere.

In this case we can get no family history. After his condition had continued some time, it became evident that this man's constitution was failing to throw off the disease. In what way did this show itself? How are we to tell that a croupous pneumonia is passing into croupous phthisis? We will be led to fear this if the solidification remain, with loss of flesh and strength, a tendency to night sweats, and the expectoration of purulent matter continue; and if, in this condition, hemorrhage occurs, it is an ominous sign that breaking down of the lung tissue is not far distant. This man has had hemorrhage. If, in addition, we have in one spot the râles becoming larger and looser, if the respiratory murmur becomes cavernous, increased in volume and more hollow in character, if the vocal resonance, instead of being simply intensified, becomes pectoriloquous, there are reasons to fear that at that spot breaking down has occurred, with the formation of a cavity.

Now before this occurs, as I have already told you, one of two things must happen; either the inflammatory exudation passes into a state of cheesy degeneration, breaks down and involves the walls of some of the air vesicles, or else a portion of the lung becomes gangrenous and necrosed, and is cast off as a slough, leaving an unhealthy abscess. The former of these is, I think, the more common. This has occurred in this case, first in the upper lobe, in front, and then behind. Both of these were followed by copious hemorrhage. You will also find a very

grave confirmation of your fear if the condition show a tendency to spread to the surrounding part of the lung, that is to say, the nutrition of the rest of the lung becomes so involved that slight causes serve to set on foot attacks of croupous or catarrhal pneumonia.

So in this case, within sixty days I found an attack of catarrhal pneumonia developing in this upper lobe of the left side. This passed away to a great extent, but left behind it a state of irritation, so that this spot has from time to time been the seat of recurring catarrhs. If, then, a patient has had a croupous pneumonia, which instead of terminating in ten or fourteen days passes into a state of consolidation, caused either by the violence of the attack or a weakness of the constitution, there is reason to fear that that patient will pass into a state of croupous phthisis; and if, while the solidification continues, there are developed hectic fever, night sweats, progressive emaciation and loss of strength, with the physical signs previously referred to, our fears are confirmed and we recognize that destruction of tissue has set in and pulmonary phthisis resulted.

I need not tell you that such a person is very liable to get tubercle, and true tuberculosis to be established. In this patient, I do not think that tuberculosis has occurred. The subsequent attacks that I have mentioned were evidently of the nature of recurring catarrhal pneumonia. Now such is the history of most cases of croupous phthisis. At a certain time the change occurs; it may either be ushered in by hemorrhage, or it may take place slowly and only be recognized by the change in the physical signs.

Croupous phthisis is not nearly so common as the form we will next study, catarrhal phthisis. But before leaving this subject I wish to point out to you what I called your attention to last week, that is, the liability of phthisis to become associated with fibroid change, which may, if the patient live long enough, pass into fibroid thickening of the lung; the exuded matters pass into a state of cheesy degeneration and are expectorated, and a process of interstitial thickening takes place, leading to fibroid condensation of the lung. Where this occurs we find certain changes which will be instructive for us to examine at this point.

Perhaps the most marked and earliest evidence of this will be progressive contraction of the affected side, flattening of the thorax, as is shown by actual measurement. In this man, Taylor, the left side has, in a moderate degree, undergone this process. You notice that the percussion note is flat over the upper portion of the lower lobe of the lung in front, while over the lower part there is resonance, which is almost tympanitic in character, very large in volume. This is associated with scattered moist râles throughout the anterior part of the chest. The apex of the heart has been drawn upward and to the left, until it now pulsates in the fourth interspace, an inch outside of the line of the nipple. The stomach has been drawn up, by the contraction of the lung, until it occupies the position over which resonance was so marked.

I say, then, that the changes which will indicate the passage of the lung into fibroid phthisis will be, in the first place, contraction of the affected side, which is contracted in all of its diameters. This may go on to such a degree that, as I have seen, the heart may beat in the third interspace, or if the right side is affected, the apex may beat outside of the right nipple, or the contraction of the lung may be so great as to draw the trachea so to one side that it will enter the thorax at the inner third of the clavicle. If the other lung remains healthy it will undergo compensatory enlargement. Where there has been a croupous exudation we will find that the patient continues to expectorate cheesy matter. We also find that the evidences of a cavity continue, the râles, cavernous respiration and pectoriloquy persist. The fever usually becomes less marked, and if the patient has no marked tendency to the development of tubercle, he may last for many years, in a state of invalid health. We constantly have patients in this hospital suffering from fibroid phthisis, which has lasted for from five to twenty years. Last year I made an autopsy of one of these patients, who, to my own knowledge, had been in the hospital for fifteen years, in whom the right lung had contracted to a very small bulk, and all the other changes were well marked.

I shall return to this subject again; I have referred to it in this connection because it is principally in croupous phthisis that we have this fibroid change occurring. I shall leave the discussion of hemorrhage from the lung until we study catarrhal and tubercular phthisis, in which it is more apt to occur.

I have here a typical case of chronic catarrhal phthisis. I think that catarrhal phthisis is fifty times as common as croupous and tubercular phthisis put together. It is *the* form of phthisis which really gives to pulmonary phthisis its frightful importance. There is no part of the world which is exempt from the ravages of catarrhal phthisis. You will see certain places mentioned that are said to be entirely free from

phthisis, but investigation has always shown such statements to be false. There is no part of the human race among whom it does not exist; but just as population increases, and as the conditions favorable to its development arise, you will find that phthisis is almost as common in one place as another.

Next week I will spend the hour in the consideration of catarrhal phthisis.

COMMUNICATIONS.

ON THE NATURE AND TREATMENT OF BURNS AND FROSTBITE.

BY GEORGE HALSTED BOYLAND, M.A., M.D.,
Of Baltimore, Md.

Wounds are either of chemical or mechanical origin. Extremes of heat and cold produce much the same effect upon the human body. Whether the chemical action be by means of the sun or by mechanical heat, such as fire or caustic acids, or again, by extreme cold, that part of the organism exposed suffers in the same manner, the same pathological process is gone through, and the character of the wound is essentially the same, though varying, as the case may be, in intensity and extent. By a brief study of these different methods of action of heat and cold their analogy will be made more apparent, and will be our guide as to the treatment of wounds caused by them. This treatment will be modified as circumstances may demand, but will always be conducted upon the same general principles.

The rays of the sun—for these claim attention as the first in the division mentioned—produce upon the parts exposed to them hyperæmia, followed closely by a superficial inflammation, erythema; if allowed to beat long and freely, blisters may make their appearance, or even a demolition of the superficial layers of the skin may be brought about; this, however, is rare, as the parts are usually withdrawn before it comes to that. Oftenest a burn of this kind in an erythematous form is found on the head, neck and shoulders of individuals when these parts, during the heat of summer, are exposed to the rays of the sun. Out of a given number of men thus exposed it will be noticed that but few are burned; the reason is, obviously, that their skins being more tender have consequently less power of resistance. The nervo-sanguineous temperament seems especially susceptible. When the cutis of the head alone is exposed to such a burn, the inflammation assumes a more aggravated type, becomes congestion of a marked character, attacks the galea aponeurotica, the meninges, and even the brain, producing that condition which has received the name of "sunstroke," in distinction from the milder form, "sunburn." As in sunburn there is visible upon the cutis necrosis of the epidermis, so in the mucous membrane of the lips, which appear tumefied and protruding, there is peeling and cracking into patches, of the epithelial layer. This is replaced but slowly, and at first by means of imperfectly formed cells; consequently, after such a burn a catarrhal condition can last for a long time. The best examples of this process are sometimes observed in the lips of those working in fields during the harvest time. A long-lasting and oft-repeated burning of this character produces a condition that may, not inappropriately, be termed chronic. The epidermis becomes thick, the cutis dry, losing its smooth, shining appearance, and assuming a darker hue. If the rays of the sun were the cause, the hue will be brown, evenly developed; but if this condition is brought about by artificial heat, the part of the skin affected will be unevenly browned or marbled, and characteristic gaps or crevices appear here and there, especially in the middle of such a burn.

In Germany are to be seen old people whose legs, from continually warming their feet on iron stoves, and old women whose thighs, from often sitting over braziers, present such cracked and wrinkled places.

Mechanical heat. The flame, for example, not only burns immediately the parts with which it comes in contact, but also inflames (lights) them to a greater or less degree in direct proportion to the severity of the burn. Although the burn may be quite insignificant, still the parts burn of themselves, however little. The action of the flame, then, is to perfectly dry the parts it touches to such an extent that they themselves are in condition to produce a new flame, although they contain more than 75 per cent. of water. Dupuytren supports this opinion, noting emphatically with what rapidity burning clothes cause burns to a considerable depth. So far as observation goes in such cases, it is not so much an active burning as a passive burned, or in some instances, almost charred condition that is to be handled. This burning (lighting) of the part affected is limited to the fat, and then only exceptionally, lasting but a moment, as any one may notice by the application of the white, glowing platinum wire in galvano-caustic operations. As the process known as flame consists

of gases heated to the highest degree, its working is similar to that of all gases heated to intensity, also to water which, through heat, has taken a gaseous form, especially when under powerful pressure—from machinery, for example—it has reached a higher temperature than the boiling point—steam. The elastic, fluid nature of steam causes it to penetrate into all openings, and therefore, scalding of the nostrils, mouth and larynx can take place in one coup, when patients are victims of boiler explosions, etc.

Dropable fluids do not work with such swiftness as steam or gases, but are apt to spread to a greater degree and cause very extended burns. If they soak the clothing their work lasts longer, although its power is constantly diminished. Temperature being equal, the intensity of the burn stands in direct proportion to the thickness of the liquid. Therefore, oil, lye, and other concentrated salt solutions produce more mischief than broth or milk, and these in their turn are more nocent than water. The more concentrated a salt solution is the more severe the burn. Therefore the bursting of retorts, etc., in chemical laboratories and manufactories, cause burns of very grave import. The thicker fluids are the more dangerous, on account of their greater heat capacity, and because they stick faster and evaporate but little, if at all. These differences are based upon the boiling point as regards oil and water. The different degrees of burns are as many as the many authors, on grounds more or less theoretical, choose to make them. Margolini and Ollivier distinguish two; Fabricius Hildanus, Boyer, three; Heister, Callisen, Bichat, four; Dupuytren, six. For practical purposes, however, the several stages of burn are best resolved into three; 1st. Inflammation without exudation under the epidermis. 2d. With exudation, blisters and pustules, followed by suppuration. 3d. Death of the parts, gangrene, formation of thick crust. The first two degrees only will claim especial attention, as being those in which the picture most resembles sunburn, burns by chemicals, and the first stages of frostbite. In all these burns there is a certain period during which the pathological course is markedly the same. That point passed, they seem to diverge somewhat, but never lose altogether their relationship. The burns that present themselves to be classed in the first degree are characterized by diffuse redness and noticeable swelling of the skin. This redness, like rose spots, disappears if the finger is passed over it and returns when it is taken off; there is a feeling of heat, burning pain. After a few days the heat and pain disappear and peeling of the epidermis begins. This does not take place if the redness and pain have only lasted a few hours. Fever only comes on when the burn is very extensive. In that case the tongue becomes red, there is great thirst, diarrhœa and vomiting, sleeplessness, delirium, convulsions, and even death, in this first degree of burn; death at once or after a few days, caused either by the intensity of the nervous affection or by congestion and inflammation of minor organs. The latter is especially the case when the burn attacks the head. Burns of this degree naturally imply that the agent, be it heat rays, or flame, or steam, or hot water, or hot solid body, or chemicals, did its work quickly, passing rapidly over the parts. When any one of these agents remains longer in contact with the human body, the more active working thus produced causes a burn of the second degree. With at the beginning violent, burning, later on stretching pains, blisters arise of different sizes and more or less numerous. This takes place generally immediately or within a very short time after the burn. The blisters are formed by an exudation of the cutis which pushes the epidermis up from it. These blisters not unfrequently burst of themselves, on account of the force of the exudation, but are more often torn or mashed accidentally; the inflamed dermis is then laid bare, the pain is increased, and suppuration more or less marked appears. The flow of pus ends with restitution of the epidermis, leaving no scar, or at most a wrinkled process like that before mentioned. Around the blisters is always found the first degree of burn, forming a red, swollen base, upon which they sit. The art of surgery is in this instance, at least, better than the *vis medicatrix naturæ*; for if these blisters be broken by a thoughtless movement or any unforeseen circumstance, the inflammation and attending suppuration are increased. On the other hand, removing their contents, which consist of a light-yellowish fluid, partaking of the nature of blood serum, is not followed by any such bad consequences. They should be emptied without disturbing them or exposing the dermis; best by a prick at the base with a needle.

A few years ago several cases of burn came under your author's observation, caused by the explosion of a barrel of petroleum in a cellar, bursting open the cellar door above and burning severely several men standing about, which, by the sudden and powerful action of the agent, placed the burns at once in a condition that can-

be described as compound, a condition, moreover, differing from those met with in ordinary practice. The several degrees of burn exist, each complete in itself, and do not run into each other as the stages of other affections. These cases formed, apparently, an exception. The parts burned were the head, face, neck and arms. The hair was well singed; the epidermis peeled off—was rolled back in great layers, and the dermis presented a bright red, inflamed, and somewhat tumefied appearance, the numberless pores looking like the heads of so many small black pins. The first point that attracted notice in these cases was, that the peeling off of the epidermis, which usually takes place after several days, the heat and pain having almost disappeared entirely by that time in burns of the first degree, became the most prominent feature at the very beginning. There was, therefore, no possibility of blisters, which so strongly characterize burns of the second degree at the outset. But the skin was in condition to commence at once suppuration, a phenomenon which is very apt to occur as the last in burns of the second degree.

The pathological relations between burns of different degrees caused by mechanical heat and burns of different degrees caused by the rays of the sun, is by the foregoing made sufficiently evident. The same will be found to exist both in burns caused by chemicals and in frostbite. After a short consideration of these in their general relations to the subject in hand, the question of therapy will be introduced. The chemicals most commonly producing burns, are, briefly, oil of vitriol (sulphuric acid), nitric acid, concentrated lye, as is often used in the manufacture of soap, sometimes caustic potash, nitrate of silver, and quicklime. The burns in this category are accomplished with such power and rapidity as to assume at once the third degree, the disturbance generally limiting itself to the cutis; deeper burns of this kind only take place when a very large quantity of the agent is left to work for a long time on the parts. Oftener than such cases, are observed intentional ones, where, in suicidal attempts, the mouth, œsophagus and stomach are burned, for instance, by corrosive sublimate. When the given chemical, sulphuric acid, if you please, comes into contact with organic parts, these lose, at once, their proportion of water and are hypothetically changed in such a manner that the atoms of hydrogen and oxygen contained therein unite to form water, and as such go over into the sulphuric acid, leaving behind a burned, dark brown crust. The working of sulphuric acid is analogous, therefore, to ordinary burning, not only in its outward results but also in its physico-chemical process. Nitric acid leaves a yellow crust, which may serve as a differential diagnostic point; important, as it is the only one. The yellow crust caused by nitric acid, in distinction from the dark brown crust caused by sulphuric acid, has, doubtless, its explanation in the fact that nitric acid does not take water so actively from the tissues as sulphuric acid, and brings about, therefore, a less complete burn, but causes none the less a disturbance of equal gravity. Among the alkalies quicklime oftenest produces serious burns. Not unfrequently children are the victims, from playing about where lime is being burned or slacked.

Caustic potash burns with much greater force and to much greater depth. Brought into contact with the body, it draws from the tissues their proportion of water, with almost the same rapidity as sulphuric acid, causing formation of water out of the hydrogen and oxygen contained in them. It differs, however, from sulphuric acid principally in this respect, that it dissolves the fat as well as the albuminoid bodies, and then forms a burn crust of an unctious, half-liquid character, which nevertheless becomes, later, perfectly dry through vaporization and the influence of the carbonic acid in the air upon the potash contained in it. The circumstance that the combination of potash with the tissues is soluble, accounts for the fact that burns caused by caustic potash rapidly attain a considerable depth. And yet, as they get toward the depth they become less severe; for the solution of caustic potash is diluted more and more the further it goes, from taking up water out of the tissues themselves. Cold produces upon the tissues the same pathological results as heat, varying according to the degree and the length of time the parts are exposed. We distinguish, therefore, degrees of frostbite similar to those of burn. The most intense effect of cold upon the general system (frost asphyxia) is, doubtless, due to the same direct cause as sunstroke, namely, congestion of the brain. Ordinarily, frostbite may be divided into three degrees, in the first and mildest of which redness and swelling of the parts are noticed; this redness passing soon over into a violet or blue color, the swelling remaining, gives to the whole a livid and tumefied appearance. The pain is an intense burning—the same exactly as experienced in burns. This pain develops itself either at the moment the cold begins to work or makes itself felt first when the frozen part is warmed. Approach to the fire

increases it. If this mildest form of frostbite is not healed at once, it becomes chronic, commonly known then as chilblains (perniones), which get better or entirely disappear in summer, return in winter, and give especial pain with changes of temperature. The chronic stage is influenced by heat and cold in a manner directly opposite to that in which the acute stage is influenced by them. The main feature of frostbite of the second degree, like that of burns of the second degree, is the development of blisters. They rise at once, often; often only after several days. If the frozen part, however, be placed in quite moderate warmth the blisters rise almost immediately. The swelling is usually much greater than in the first degree, the pain somewhat different. Patients of this class will tell you that there is a sensation as of the skin being stretched, with painful "stickings" through it. The resemblance between burns and frostbite of this degree is, in some respects, very marked. As the course goes on and the so-called reaction sets in, one difference becomes quite apparent, which is, that the processes brought about by burning have an active and acute character; those, on the other hand, caused by freezing, are very torpid, and always have a certain tendency to gangrene. This fact will explain partially, at least, the contents of the blisters, which, unlike that of burns of the second degree, are never watery or even light yellowish, but rather of a bluish red, sometimes gray or gray blue, and always turbid. Only seldom is the epidermis under the blisters renewed. As a rule, they are burst or torn, and ulceration, which secretes ichor, follows. As chilblains were not improperly styled the chronic stage of frostbite of the first degree, so, with equal propriety, is the chronic stage of frostbite of the second degree marked by frost ulcers (*ulcera ex congelatione*) caused in the manner just mentioned, and which, usually, on the hand or foot, can, little by little, lay bare the bone. In the third degree of freezing, as in the third degree of burn, the most notable point is mortification—death of the parts. These are white or gray spots, which, as in the third degree of burn, are caused by the gangrenous disturbance of the papillæ of the skin. By the most intense working of cold the whole skin of the part becomes at once gangrenous, although at first pale and smooth; it then assumes a gray or blackish hue. And in this extreme degree of freezing the whole thickness of the limb dies.

A comparison between frostbite and burns of any kind reveals their general pathological relationship; there are certain differences which we have endeavored to point out; but they are differences as to physical detail, and do not interfere in the least with the broad morbid anatomical principle that obtains throughout all their courses. And thus a guide is furnished in

Treatment.—There is a punctum saliens in burns, if in any surgical disease, and that is inflammation. In their treatment, then, everything must be directed from an antiphlogistic basis.

The effect of heat upon the tissues being, as has been shown, to draw watery constituents from them, those means which would help to restore the tissues to their normal condition in this respect commend themselves to our use in the therapy of injuries due to causes such as have been mentioned. In the treatment of simple burns of the first and second degrees not accompanied by denudation of the epidermis, cold applications produce always excellent results. When practicable, plunge the part affected into a cold-water bath, having care to renew the water as frequently as necessary in order to keep it at the lowest possible degree. When immersion is impracticable, compresses wet with cold water may be used; these must be kept at the temperature at which they are first applied, by pouring cold water upon them at short intervals. The liquor plumbi subacetatis dilutus will be found very cooling and agreeable to the patient, but as far as therapeutic effect is concerned, cold water will accomplish as much. The law of "*similia similibus*" does not find an illustration in exposing the burn to intense heat by approaching it to the fire; the writer has found that to always increase the pain, and has never seen the slightest good effected by it. Ether, alcohol, cologne water, and, in fact, almost any volatile liquid which, by its vaporizing property, carries off more or less caloric will be found useful. Preferable, for me, however, are those topical emollient solutions which have a resolvent and mild repercussive action, such as oil of sweet almonds, olive oil, or linseed oil and lime water, camphor water and gum arabic. In the cases referred to in the first part of this article, resulting from the explosion of a barrel of coal oil, linseed oil and lime water were used in some, a solution of permanganate of potash and water in the others; all made good recoveries. The permanganate of potash answers well as a dressing in the muco-pus secretion of the lips sometimes met with in those working in the field in the summer, and exposed to constant sunburn, of which this catarrhal condition is the result. In the ordinary acute sunburn of the face, cold cream is all that is necessary. Sunstroke, be-

longing to inner medicine, will not be considered here. The application of leeches upon the parts inflamed, in burns of the second degree, is of service when the local irritation is very lively, tenacious and accompanied by much swelling. It has already been hinted that the blisters should be opened by a small puncture at the bottom, and so important is this that it will bear repeating. Care must be taken not to destroy the epidermis, but to let it collapse and form a covering for the dermis beneath. If, by chance, the epidermis should be destroyed, the cerates on soft linen find a place. When suppuration is fully established, antiseptic dressings commend themselves, with good reason: these should be continued until the phlogosis entirely subsides.

Bicarbonate of soda has, so far as personal experience goes, proved an excellent, cheap and quickly acting dressing in burns of the first and second degree, that is, for the general practitioner, in all ordinary burns. The method of sprinkling it on the wounded surface is less efficacious than that of applying it in solution, on fine, soft linen, thoroughly soaked, not wrung out, but gently laid over the entire wounded surface and covered with a dry piece of the same material, care being taken to avoid all pressure. This solution should be a saturated one, which will cause no difficulty to arise as regards too strong a growth of granulation; it is also valuable as a means of relieving the pain. If, when a patient is first seen, the constitutional symptoms are grave, and anything like stupor prevails, it is the duty of the surgeon to combat that first, by frictions of the healthy parts, sal volatile, slightly stimulating drinks and antispasmodics. In burns of the third degree, efforts to establish suppuration by emollient cataplasms, with opium if the pain is severe, will probably fail, and our only recourse will be to amputate the dead parts. In the treatment of burns caused by chemicals, such as sulphuric and nitric acids, our first care must be to neutralize their action by alkalies; salts of carbonic acid, chalk, soap and magnesia. They must afterward be treated as other burns. The treatment of those burns caused by alkalies, caustic potash and lye, must be conducted in like manner, with this difference, however, that the neutralization is, in this case, to be accomplished by acids, such as are harmless and can be quickly got at—vinegar, for instance.

Frostbite. Frostbite demands, imperatively, treatment by cold. In all degrees of frostbite frictions should be made at once, with ice and snow. In cases of frost asphyxia, the whole body, naked and in a cold room, must be rubbed with ice and snow, then placed in a very cold bath, the rubbing being continued. If life begins to return, the body can only gradually be brought into a higher temperature. Of course, when necessary, artificial respiration will be kept up, best on Byrd's plan (described in *The Practitioner*, for January, 1880); electricity applied to the diaphragm will aid materially. Frozen extremities must be treated in the same manner; if not successful, pushing off the gangrenous crust should be induced by stimulating cataplasms. If the gangrene has embraced the entire thickness of the limb or extremity, amputation is the only course left, but should never be undertaken until the demarcation line between the dead and living tissues is unmistakable.

Chilblains and frost ulcers are quite curable, demanding a long continued excitant treatment, owing to their torpid character. They return frequently, however, and are often stubborn. Rubbings with ice and snow come first in the long list of remedies; then follow bathing with a strong solution of chloride of lime, painting with iodine, with mineral acids, petroleum, tincture opium or cantharides, myrrh, camphor, balsam of Peru, and so on. There are other and different applications, but the principle is the same. And this brings us back to the point from which we started. But let us remember, in the treatment of all wounds, Ambrose Paré's words: "I dressed the wounds, God healed them."

Hospital Reports.

JEFFERSON MEDICAL COLLEGE HOSPITAL.

CLINICAL LECTURE BY W. W. VAN VALZAH, M.D.

Reported by CHARLES R. CRANDALL, M.D.

Epilepsy.

GENTLEMEN—The first case I shall show you to day will illustrate one of the forms of epilepsy, and is also one that brings out a valuable point in therapeutics. This young man came to the hospital and complained of having fits from time to time. He tells us that he began to have them about three years ago, while attending school. At that time they came at long intervals, as, for instance, one in every three or four months. They generally occurred after prolonged application to study, and especially during a period of overwork, when striving to insure advancement into higher classes. He says, too, that they come on either in the day or night, and that the attacks are characterized, so his friends have told him, by sudden loss of consciousness, falling down, twitchings of the muscles, all of which is followed by prolonged sleep. At first he had only one in three or four

months, but the intervals between paroxysms have gradually shortened, until he now has three or four a week. I have questioned him quite closely, in order to get at the cause of the attacks, but cannot satisfy myself entirely. He says, however, that he has noticed that the attacks are most likely to occur when his stomach is out of order, and his system tired and exhausted, from prolonged mental application. He denies ever practicing self-abuse, or having spells of mental excitement, or having received any blow or injury on the head.

I am also unable to obtain any trace of hereditary tendency which would predispose him to the disease. The case appears to be one of the idiopathic group, where it is impossible to find any well-established cause.

In looking at this patient you see he is not a vigorous looking youth. His frame is small, his flesh spare, his features angular and his face pale. On inquiring into his general health, it appears to be in fair condition, and he informs me that his appetite is good and his bowels regular. The intellect does not seem to be impaired, nor does it always suffer in cases of epilepsy. History gives us notable instances of great men who suffered from epileptic attacks. You remember that I gave you the theories as to the causes of epilepsy in my last clinic, as well as the modern views regarding the portion of the brain involved. I then said to you that modern authorities accept the view that the disease results from a disturbance of the pons varolii and medulla oblongata. That disturbance may be due to a change in the structure in or about those parts, or to irritation reflected there from other portions of the body. In the case of our patient, I think that the disease was induced by excessive mental application, which gave rise to irritation and functional disturbance of those important centres.

Treatment.—What I especially desired to call your attention to was a peculiarity of the action of our usual remedy in cases of this kind. He has been receiving treatment elsewhere for weeks, and was placed, at first, on the bromide of potassium. He took from ten to thirty grains three times daily, without being at all benefited. Clinical experience has taught us that cases in which the bromides by themselves have failed often respond well to treatment when the iodides and bromides are combined. We resorted to that combination, and this young man has been taking as follows:—

℞.	Pot. bromide,	gr. x	
	Pot. iodide,	grs. viij	
	Infusum gent.,	ʒ ij.	M.

Three times daily.

To-day he reports himself much better. I added the bitter in this prescription in order to keep the stomach in as good condition as possible. We also advised in this case a plain, nutritious diet; and he tells you that he avoids rich food, living chiefly on milk, oatmeal and other light foods. He has been especially requested to eat a light supper, which he says he does.

Note.—This party has returned every week for four weeks, and reports that he has not had an attack.

Aneurism.

The case which I now present to you is one of profound interest. This man's name is Joseph L., aged thirty-eight years. He is a sailor by occupation, and most of his voyages have taken him into the Southern States and the West Indies. He says he always had good health up to eight or nine years ago, when he had bilious remittent fever off and on for three or four years. Subsequent to that time, he says, he has had bone fever, swamp fever, chills and fever, and rheumatism. These fevers he speaks of are all local names for different forms of malarial attacks. During the year 1875 he had his first attack of rheumatism, and since then has had several more. These attacks were severe, giving rise to high fever and sweats, coated tongue, and painful swelling of the large joints. I inquire as to specific contamination, and find that he had a primary sore twenty years ago. According to what he says there was no secondary involvement, as is shown by buboes, enlargement of other glands, eruption on the skin or falling out of the hair. As confirmatory of his statements I am unable to find any traces of that disease about his person. He has been in good health up to about two months, when he took cold, and had some pain in his lungs. This state of things lasted for about a month, when he noticed a throbbing in the upper portion of the anterior side of the right lung. I now have him remove his clothing, so as to expose his chest, and ask him to tell us more about his trouble. He says he feels this swelling, is conscious of a throbbing in it, and has some pain in the right lung and in the right arm, whether he attempts to raise it or not.

Physical Examination.—Let us now proceed to examine this man according to the usual method. As I inspect his chest I see on the upper portion of the anterior surface of the right side a peculiar bulging. As I look at the bulging point from a side view I can see it beat or throb. Having thus inspected his chest, I now resort to palpation. I place my hand where the heart should be and find it in its normal position, so we must at once exclude the idea of a displaced heart. Placing my hand over this bulging portion, I notice a peculiar heaving or expansive sensation, very different, indeed, from the impulse felt over the heart. Furthermore, this sense of expansion covers a larger space than the impulse given by the heart, and besides, I fail to discover anything like a thrill. Having gained all I can from palpation, I percuss this portion of the chest, and try to trace the outlines of the bulging. I find an area of dullness of about three or four inches in diameter, and it is situated about an inch to the right and a little below the junction of the clavicle and sternum. It extends from the second interspace above to the fourth interspace below. As you hear when I percuss, this area is almost flat when compared with the normal percussion note of the lung.

I now auscult the chest, and find the murmurs normal on both sides. The patient complains of some cough, but that is doubtless due to slight irritation produced by pressure, and not to bron-

chitis or any disease of the lungs, as I do not detect any abnormal sounds.

Listening to the heart, I find the sounds normal, but the action is a little rapid and irregular. There is an absence of the heaving and expansive sensation, such as is found in the region of the tumor. The heaving of the tumor corresponds in point of time with the action of the heart, but it appears to be more powerful and covers more surface. I am unable to discover any murmurs or blowing sound in the tumor. Placing my fingers on the pulses, I find them nearly normal, which indicates that the tumor does not, as yet, press heavily enough on the vessels to impede circulation. The man says that he has not experienced any difficulty either in swallowing or in the use of his voice. The pain of which he complains in the right shoulder and arm is doubtless due to pressure on filaments of the brachial plexus. Examining the pupils, I find them unchanged.

Before entering into a discussion of the diagnosis, I wish to see if any member of the class has an opinion to offer as to what we are dealing with. I hear some one say, "aneurism of the arch of the aorta." The opinion is a correct one, and I will endeavor to point out why it is so. In the first place, this enlargement has developed rather rapidly, which is characteristic of aneurismal growths. The fact that I fail to get any thrill or murmur is no argument against our diagnosis, for it is not uncommon to find aneurisms of the thorax without either. Again, it is possible to have an aneurism in this location without having any marked signs, such as coughing, difficulty in swallowing, shortness of breath, etc., because the sac may point forward, and may not be large enough during the first stages to give rise to much disturbance. You must bear in mind that in all probability this aneurism has existed only a few weeks, and therefore it is too soon to look for marked physiological disturbance.

Where shall we locate the aneurism? I am confident that it is in the ascending portion of the arch. First, because it is on the right side of the sternum, and below the second intercostal space. If the aneurism was in the transverse portion it would have been in the median line. If it was in the descending portion it would have been on the left side. Lastly, if it was in the innominate artery it would have been above the second intercostal space, and well under the clavicle.

Again, it is well established that, as a rule, the larger portion of aneurisms which come in this vicinity have their origin in the ascending portion of the arch of the aorta. This fact alone would give a strong probability to the accuracy of our diagnosis.

The question may have arisen in your minds, is this not some other kind of a tumor? I think it is not a solid or mediastinal tumor, for the following reasons: If this was a tumor of that nature we would not have the heaving and expansile pulsation so pronounced in this case. It is true a tumor might pulsate, but would do so only in cases of excessive vascularity and soft consistency, or in case it overlaid a large vessel. It is hardly possible that a tumor could have grown so rapidly, and have become sufficiently vascular to cause the marked heaving and throbbing we have here. Furthermore, tumors in this locality are almost invariably cancerous. They are of slow growth and painful; they may also present the cancerous cachexia. They cause lymphatic enlargement and marked involvement of the constitution. It is evident to you all that we have no such history or symptoms in this case.

Having finished our diagnosis, I wish to say a word regarding the varieties of aneurisms. There are three chief varieties, diffused, fusiform and sacculated. Aneurisms are diffused or false when all the coats of the vessels are ruptured and the blood diffuses into the adjacent tissues. The fusiform variety is where the vessel takes the shape of a spindle. An aneurism is sacculated when one or more coats of an artery give way at a certain point, allowing the pressure of the blood to cause the remaining coat or coats to pouch or bag in a certain direction. It is safe to say that the aneurism in this instance is sacculated, for that is the usual variety or form occurring in this locality.

Now the question arises, what should cause this aneurism? I may say, in brief, that aneurisms usually result from straining, atheromatous degeneration, rheumatism, gout and syphilis. Although our patient's work subjected him to heavy lifting at times, he does not remember having felt any strain, nor does he remember that this tumor followed soon after specially hard work. We cannot attribute it to atheromatous degeneration, because the man is too young, and the superficial arteries do not show the usual evidence of such structural changes. Neither can we assign it to gout, for there are no symptoms of that disease. While there is a remote history of syphilis, which would suggest that disease being the predisposing cause, there is no evidence of either secondary or tertiary involvement. Hence we are narrowed down to the belief that this aneurism is due to certain changes having taken place in the coats of the artery, as a result of frequent and severe attacks of rheumatism. It is possible that the repeated attacks of malaria increased these degenerative changes.

In the treatment of this case, the chief indication is to secure, if possible, coagulation. In order to accomplish this, the first thing to do is to insist upon absolute rest. This man should be kept in bed, flat on his back, not allowed to walk about, much less to lift or strain. It stands to reason that not a thing can be accomplished if the heart is kept over-acting. The rapid current of blood will not permit coagulation, which is the great desideratum; in fact, it would not only prevent coagulation, but the increased pressure would cause the sac to enlarge.

In the sacculated variety coagulation often takes place quite readily, far more so than in either of the other varieties; hence, we have reason for hoping to accomplish something by our treatment. The remedial agents we shall employ in this case are ice and the iodide of potassium. It has been found that ice, applied over the aneurism and kept on as long as the patient can bear, seems to favor coagulation. In regard to iodide of potassium in this disease, it

often does much good. Roberts and Balfour, of England, seem to have used it to great advantage in a series of cases. It must be given in large doses. This man is now taking twenty-five grains three times daily. His stomach bears up well under it, and we shall increase the amount to thirty grains three times daily. The patient says for himself that the bulging and pulsation have decreased under the treatment.

Chronic Phthisis.

I am enabled with this patient to demonstrate to you the various methods for making physical examination of the chest, as well as to show you a case of considerable interest. This man's name is John F., aged forty-one; he is a huckster by occupation. Fifteen years ago he was an orderly in the army, and his duties exposed him to hardship and bad weather. At that time he contracted a slight, dry cough, which has continued ever since. During the sixteen years mentioned his general health has been fair, his appetite good, and he has not suffered from hemorrhages from the lungs. Within a few months, however, he has noticed a decrease of strength and an increase of cough and expectoration. I ask him the nature of the matter expectorated, and he replies that it is thick, frothy, and floats in the vessel. As we look at this man's face we notice the general expression of the countenance to be bad. It is a countenance at once suggestive of disease. There is every evidence of anæmia, shown by the general pallor of face, lips and conjunctiva. The tongue has a tolerable good appearance and he assures me that his appetite and digestion are good. Looking at the man as he stands before you, you notice that his form above his waist seems to lean to the right side. He now removes his shirt, so as to expose his whole chest. You observe at a glance that he does lean to the right side, and that his right infra-clavicular region is markedly contracted. At the same time you notice the bulging of the left side. His usual breathing is weak on both sides, but it is evident that the expansion of the lung is much weaker on the right side. Placing my hands, one over either lung, I tell him to take a deep breath; as he does so, you notice how my hand rises on the left side while it scarcely moves on the right. I now ask him to count one, two, three, and I find the trembling is pronounced, compared with the left side. Having learned so much from inspection and palpation, let me now percuss him. At once I disclose marked dullness in the region of the right anterior apex. This dullness diminishes as I pass down toward the nipple. On the left side of the chest percussion resonance is normal. Over the right lung, posteriorly, there is some dullness at the right apex, but less marked than anteriorly. I now auscult the chest and ask the patient to breathe a little stronger than usual, but in a regular manner. It often happens that a patient breathes too strong, and breaks the rhythm, and changes the character of the breathing in other ways. I find feeble breathing on both sides, and as he now breathes more naturally, I can hardly hear the normal murmurs. There are no râles to be heard, but I discover an occasional harsh click and prolonged expiration. Placing my ear over the left lung, I hear marked supplemental breathing, which is due to the impaired condition of the right lung. Voice auscultation is markedly increased on the right side, and as I listen posteriorly above and below the spine of the scapula, I hear distinct cavernous breathing. Reverting again to percussion on the right side, I fail to get the "cracked pot" sound which is usually heard when there are cavities situated superficially and connected with bronchial tubes. I think I fail to get the sound, owing to the deep situation of the cavity. As a rule, cavities are more discernible on the anterior surface, and are superficial, but in this case I should say that the cavity is situated deeply within the structure of the lung.

The temperature of this man is somewhat above normal. The temperature is usually raised, in this disease, and it is markedly influenced by the rate of progress. So long as the temperature remains about normal the disease is stayed, from some cause. On the other hand, when the temperature ranges 102–103 it indicates rapid progress. Placing my hand on the pulse I recognize that it is accelerated, which is what we might expect in a case like this. The pulse is often accelerated in this disease, and when it is rapid, associated with the other symptoms, it aids materially in making a diagnosis.

You, doubtless, all anticipate me when I pronounce this to be a well-marked case of phthisis. I have not only been able to demonstrate to you the methods of chest examination, but besides, to present many of the characteristic features of the advanced stage of phthisis. In going over this case we have found successively a history of cough, failing strength, general anæmia, contracted chest, cavernous breathing, dullness at the apex, increased vocal fremitus, increased voice auscultation and prolonged expiration. The diagnostic significance of such a group of symptoms and physical signs is serious indeed, pointing, as in this case, to the ravages of a resistless disease.

Now, the practical question arises, What can we do for this man? Let me say in the first place that it is always best not to medicate too much. If an attempt is made to treat all the indications at once, there is danger of breaking down the digestion, and doing more harm than good. In this man's case his appetite and digestion are now good, and it is of utmost importance to him that they should so continue. Therefore, we will not give him anything with a view of regulating his circulation or controlling his cough, neither of which is excessive or annoying. We will, however, endeavor to keep down his temperature, and do all we can to build him up and support his system against the inroads of the disease. Hence, I shall advise him to live generously, on such nourishing food as milk, eggs, beef, bread and butter, etc. He is to keep himself clothed with woolens, and is to avoid exposure to bad weather. He should make it a rule to be out of doors, in the sun and air, all he can during pleasant weather. The skin should be kept clean and healthy, by frequent baths. As regards supporting remedies, I shall advise that he be given nine

grains of quinine and ten drops of the tincture of iron three times daily. In addition, he should have about half an ounce of good whiskey with his midday meal.

Editorial Department.

Periscope.

Ligature of the Middle Meningeal Artery in Compound Fracture of the Lateral Parts of the Skull.

In commenting on a successful case of the above description, published by Prof. Hueter, M. Marchant states, in *La France Médicale*, Nos. 1 and 2, 1880, that an examination of the pathological and clinical facts of all the recorded cases has led him to the following conclusions:—

1st. Ruptures of the middle meningeal artery, in direct compound fractures of the lateral portions of the skull, do not present the same features in children, adults, and aged persons.

2d. In children, by reason of the intimate adhesion of the dura mater to the bone, the blood has little tendency to be effused into the interior of the cranium. The effusion is *rather extra-cranial*. This external hemorrhage may be met by ligature of the middle meningeal artery, an operation which is rendered comparatively easy by the normal position of the artery.

3d. In adults the condition is quite the reverse. That there is almost always separation of the dura mater, is proved by a great number of facts. The blood is effused in a space so fixed in size as to merit the name of the "separable zone of the dura mater." Intra-cranial hemorrhage is the rule; extra-cranial is the exception.

If, suspecting intra-cranial hemorrhage from the existence of compression, or because there is external hemorrhage, the surgeon wishes to interfere, in proceeding to tie the middle meningeal artery he will meet with almost insuperable obstacles. These are: 1. The size of the clot to be displaced. 2. The position of the artery—drawn back some 4 or 5 ctm. toward the median plane. 3. The difficulty of recognizing, in most cases, the point where the artery has been wounded; and 4. The difficulty of dealing with an artery which offers little hold to the ligature.

Treatment of Ringworm.

Mr. Wyndham Cottle, Senior Assistant Surgeon to the Hospital for Diseases of the Skin, says, in a communication on the above subject, to the *British Medical Journal*, May 29th, 1880—

After making trial of various agents, I have obtained the best results by painting the most obstinately affected portions of the scalp with linimentum crotonis, and directing the subsequent frequent use of an ointment or lotion of salicylic acid. One application of the croton oil usually suffices to produce a copious pustular rash over the parts with which it is brought in contact. If it fail to do so, the application should be repeated. An ointment of ten to forty grains of salicylic acid to the ounce of the base selected should then be rubbed over the scalp twice or thrice daily. The strength, frequency, and vigor of the application should be proportioned to the inflammatory effect that results. All crusts, scales, and diseased hairs, should be removed as speedily as possible. Though this mode of treatment is neither suitable to every case, nor universally successful, it possesses some advantages. 1. The croton oil liniment gives rise to no pain at the time of its application, while the consequent suppuration is not, in most cases, more irksome to the patient than the prolonged and acute pain that attends the use of the usual caustics. 2. Permanent loss of hair does not result. 3. The treatment is easy to carry out. 4. Many intractable cases rapidly mend when so dealt with. 5. The agents employed are not poisonous.

I usually prescribe salicylic acid as an ointment—from ten to forty grains of the acid to an ounce of lard, vaseline, etc.—and I often find advantage from combining it with other drugs, as carbolic acid or oil of cade, etc. If it be desired to increase its irritating properties, the addition of a few grains of perbromide of mercury or antimony chloride to the ointment will be effectual. Again, if an eczematous state of skin have supervened, some of the more soothing of the salts of zinc or mercury may be advantageously ordered with the salicylic acid. If a liquid form is preferred, from twenty to forty grains of salicylic acid may be dissolved in an ounce of alcohol, and the affected parts painted with the solution two or three times a day. Such solutions often set up much skin irritation.

The following points seem, then, to be worthy of consideration in the treatment of ringworm.

1. The risk of the extension of the disease should be avoided.

2. Suitable constitutional treatment should be adopted.

4. Recent cases in healthy individuals may be very well dealt with by almost any of the usual remedies.

4. In chronic and obstinate cases, the production of suppuration by croton-oil liniment, followed by the application of salicylic acid, either alone or in combination (or of any agents whose action is similar), offers a not unpromising means of eradicating the disease.

Case of Sclerema in an Adult.

The *Lyon Médicale* contains a report of the following interesting case:—

M. X., aged thirty-three, consulted M. Aubert, in March, 1877, for a cutaneous affection which had first appeared in August, 1876. Father and mother have the same disease. Of three brothers, one died of pneumonia, one of chronic laryngitis,

and one is alive and well. Patient looks healthy. He relates that in August, 1876, he was attacked by weakness, uneasiness and loss of appetite. He felt, at the same time, his body, and especially his hands, very hot, and often plunged them in cold water; the skin of the legs also felt rigid and tense when he stooped. In November following the skin on the backs of his hands and wrists became rigid, this condition afterward extending to forearms and arms. When M. Aubert first saw him, the skin of the arms, forearms and backs of the hands was hard, white and rigid, reminding one of a cast of the fingers in white wax, preserved and a little hard. There was no perspiration in the affected parts. The backs of the feet, the legs, and some spaces on the thighs presented an analogous condition. This caused a painful feeling of tension, and a little difficulty in walking, and rendered complete flexion of the fingers impossible. The treatment consisted in vapor baths, the affected parts to be covered during the night with india-rubber cloths; Vals water to be taken internally. The patient gradually improved. A month later shampooing and inunction with oil were practiced, and in a few months the cure was complete. M. Aubert remarks that the pathology of sclerema in the adult is completely unknown; that it is a special disease, and must not be confounded with sclerosis of the skin, which is simply an anatomical lesion, and may occur in many different affections. The treatment should be directed to restoring and maintaining the secreting power of the skin, and after recovery the patient should be warmly clothed.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the *Therapeutic Gazette*, April 15th, 1880, contains an article on Fluid Extracts, as proposed for the coming Pharmacopœia.

——The *Atlantic Monthly* for July contains, besides continuations of "The Stillwater Tragedy," by Thomas Baily Aldrich, and "The Undiscovered Country," by W. D. Howells, "The Saffron Fly," a legend of Brittany, by Rose Terry Cooke; "Incidents of the Capture of Richmond," by George F. Shepley; "Brown's Retreat," by Anna Eichberg; "Passing," a poem, by Alice Williams Brotherton; "Wintering on Ætna," by S. P. Langley; "Unfulfillment," a poem, by Frances Louisa Bushnell; "A French Comic Dramatist," by J. Brander Matthews; "Confederation in Canada," by Frederick G. Mather; "Reminiscences of Washington," the "Van Buren Administration, 1837 to 1841;" with numerous other articles of interest.

——*Lippincott's Magazine* for July contains two illustrated articles of a light and entertaining character—"The Palace of the Leatherstonepaughs," which is a humorous sketch of artist life in Rome, and "Paradise Plantation," which is a description, in a similar vein, of amateur farming in Florida. Dr. S. Weir Mitchell concludes the interesting account of his tour "Through the Yellowstone Park," and some peculiar phases of Western life are described by Louise Coffin Jones, in a paper entitled, "On the Skunk River." "A Forgotten American Worthy," by Charles Burr Todd, recounts the remarkable career of Joel Barlow. "On Spelling Reform" presents some strong arguments against the proposed changes in English orthography. "An Open Look at the Political Situation" criticises the course of the "Independents," and discusses the chances of Civil Service Reform. "Pipistrello," by "Ouida," is a picturesque and powerfully written story of Italian life. "Adam and Eve" and "Studies in the Slums" are continued. The poetry is by Emma Lazarus, J. B. Tabb, and H. L. Leonard, and the "Monthly Gossip" and "Literature of the Day" are as good and varied as usual. This number begins the twenty-sixth volume.

BOOK NOTICES.

A Treatise on Oral Deformities as a Branch of Mechanical Surgery. By Norman W. Kingsley, M.D.S., D.D.S., late Dean of the New York College of Dentistry, and Professor of Dental Art and Mechanism, etc. With over 350 illustrations. New York, D. Appleton & Co., 1, 3 and 5 Bond street, 1880. One volume, 8vo, pp. 541. Price, cloth $5.00; sheep $6.00.

This work is divided into five parts. Part I treats of irregularities of the teeth. After giving a description of the normal type of jaws, the author proceeds to a definition of abnormality and its various causes, whether hereditary or acquired, the correlation of irregularities of teeth to idiocy, entering fully into a discussion of the various methods of treatment, with cases from practice. The subject of Part II is Palatine Defects and their Treatments. In Part III he takes up Maxillary Fractures, their location, diagnosis and treatment. Part IV is on the Mechanism of Speech, and Part V treats of the Æsthetics of Dentistry. Each subject is handled with thoroughness and scientific skill, and while we regard the book as indispensable to those practicing dental surgery, it will be found useful to physicians in general practice as well, and is well worthy of a careful perusal.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE MEDICAL ASPECTS OF EDUCATION.

I. Ante-natal or Race Education.

The subject of Education is one of such primary importance, and one in many respects so intimately connected with questions in medicine, hygiene, physiology and sanitary science, that we shall devote to the medical aspects of it several brief articles. It is our desire rather to present the problems which it offers for the consideration of the physician, than to give any complete analysis of it; rather to suggest topics for thought and research, than to set forth the results of investigations hitherto made.

Education, in its broadest sense, means the improvement of the race of man, in both sexes, and all varieties and individuals. Looking more particularly at civilized man, under the conditions most familiar to us, we can conveniently divide the process of education into four separate stadia, as follows:—

1. Ante-natal or Race Education.
2. Household Education.
3. Scholastic Education.
4. Professional or Business Education.

At present we shall confine ourselves to the first of these.

The idea of education as a deliberate process, beginning before birth, or even before conception, though not wholly of modern origin, never took correct form previous to the recent studies in heredity, atavism, maternal impressions, inherited memory and race deterioration. The names of Laycock and Darwin, among English writers, are most deserving of mention in this connection. The former showed by many examples that the faculties of children can be influenced to advantage or disadvantage by the habits of their parents. Mr. Samuel Royce, in a recent work ("Race Education," 1878), has also emphasized the general facts of this nature, and has put in an earnest plea for the study of education in this sense of the word. Like several other observers, Dr. Nathan Allen and Dr. C. G. R. Moutoux, for instance, he believes that there is strong reason to believe that there is apparent a physical deterioration of the race, at least as it appears in this country. The subject is one for and against which much could be said; but the dangers which Dr. Moutoux points out are certainly real, and should attract the attention of sanitarians. They are, briefly, as follows:—

1. The popular aversion (now-a-days) to physical exercise.
2. The overstrain of mental labor of young children.
3. The too artificial and unwholesome way of feeding.
4. The too early use and abuse of the generative organs.
5. The often unnecessary medication in infants and children.

The means of rectifying these errors may fall a great deal to the lot of parents, nurses and teachers, yet the physician, being considered an expert to some extent, certainly will have to do his share in urging the importance of the subject. Upon him alone devolves the duty of investigating the causes and suggesting the proper remedy.

He, however, has omitted one, which has a claim to be considered the most important of all, and that is, ill-assorted marriages. This point has recently received special notice at the hands of Dr. Bourgeois, of Paris, a member of the Société de Médecine Publique. He very justly

thinks that such marriages are productive of great harm to the offspring, and he has not hesitated to bring forward a proposition that the State should take measures to prevent the marriage of individuals suffering from certain hereditary diseases which are most generally transmitted to the offspring. According to Dr. Bourgeois, by the prohibition of such ill-advised alliances, phthisis, epilepsy and mental disease would soon be exterminated. The commission appointed to examine and report upon the proposition has, as might be anticipated, concluded against it. In the French law there is only one case in which an individual is incapable of contracting marriage, and that is in the case of an *interdit*—that is, a person interdicted, on account of mental incapacity, from the exercise of civil rights, and this is on legal, rather than on hygienic grounds. For a marriage to be legal consent must be given, and as an *interdit* cannot legally give a valid consent, he cannot contract marriage. Dr. Bourgeois would have every candidate for wedlock submit to medical examination, and would allow marriage to those only who had obtained a medical license. He also thinks that a difference of twenty-five years between the ages of the two parties should constitute an absolute bar to their union when one of them is over sixty, so that a man of that age would be forbidden to marry a woman of four-and-thirty.

The growing importance of the subject is further illustrated by the fact that this summer the Sanitary Institute of Great Britain offers a prize of one thousand dollars for the best essay on "The Cause of Hereditary Tendencies in Health and Disease."

The education of each parent, therefore, and the physical and mental relationship of the two parents, become factors of the first moment in the education of the race.

But the ante-natal education does not cease here. There is a stadium of it singularly neglected now-a-days, and that is the education of the child in the womb. After long discussion, it is now definitely settled that maternal impressions exert the most profound influence on the unborn child, both bodily and mentally. Hitherto the efforts of physicians have been chiefly directed to showing this in its dark side. How monsters, and deformities, and ugly blemishes may be traced to mental impressions during pregnancy, has been amply shown; but how virtues and beauties may be just as certainly obtained has received the minimum of attention. Yet there is no reason why the same potent influence may not be directed for good as for harm, for the benefit as for the disadvantage, of the future individual.

A certain amount of evidence to this effect is accessible, but the subject is worthy much more attention than it has received. The hygiene of the puerperal state is at present mainly a negative one. Can we not have positive measures taken to influence the fœtus in the direction it should go? It appears to us there is large scope here for the professional philanthropist.

Notes and Comments.

Tuberculous Inflammation of the Internal Coat of Vessels in Tubercular Meningitis.

Besides the anatomical changes that take place in the lymphatic spaces and outer coat of the vessels of the pia mater, M. Cornil has demonstrated that the inner coat is the seat of a special pathological process. According to his observations, which have been published in *La Revue Médicale*, it is thickened by the formation of several layers of cells, which, beginning next the middle coat and going toward the endothelium, present the following form and disposition: 1. Small round cells enclosing small round nuclei. 2. Closely adjoining these are elongated cells of a cylindrical or prismatic shape, and terminated by a filiform extremity which is inserted in the elastic coat. 3. Cells of a large size (giant cells), often flattened out, of the shape of irregular plates, containing two or three ovoid nuclei. 4. Within the zone of giant cells there exist, also, prismatic cells or small round cells, irregularly placed, and forming a layer immediately subjacent to the endothelium. Thus the cells of the new formation in the inflamed lining membrane form, says M. Cornil, a true evolution, like that of epithelium, ending with giant cells as the highest of the series. The prismatic cells are the same as are found in ordinary inflammation, subacute or

chronic, of the internal coat and in syphilitic inflammation of the arteries. This tubercular inflammation ending in giant cells, is spread over the surface of the interior of the vessel, and does not affect the form of the limited granulations. The combination of the lesions of the connective tissue of the meninges, of the perivascular spaces, and of the vascular coats, constitute the little nodules or the larger tuberculous masses. In several cases of meningitis where he had carefully searched for giant cells, so common in tubercle of other organs, he found them only in the altered inner coat of the vessels. These tuberculous alterations in the inner coat of the vessels strongly support the doctrine of the infection of tubercle, as the blood itself could thus be a carrier of the infective matter.

The Diagnosis of Rötheln.

W. Gilchrist Burnie, M.R.C.S., states, in the *British Medical Journal*, June 5th, 1880, that a diagnosis of rötheln may be made from measles, by observing the following points:—1. The rash is more vivid and in smaller patches, the patches not being markedly crescentic. 2. There is no coryza nor cough. 3. There are sore throat and strawberry tongue. From scarlet fever the points of diagnosis are these:—1. The rash is in patches and less red. 2. Neither tonsils nor cervical glands are much affected. 3. The temperature rarely exceeds 102° Fahr. 4. The illness is of short duration (rarely lasting a week) and mild. 5. The patient does not affect others with scarlet fever; and albumen is absent from the urine. Desquamation occurs about the fifth or sixth day, and is sometimes profuse. In conclusion, I would say that I cannot but think it would be a great benefit to medicine if rötheln were, once and for all, recognized as quite a distinct disease.

Uræmia Treated by Pilocarpin.

We learn from *L'Union Médicale* that at the Société de Biologie, M. Leven communicated the case of a young girl attacked by parenchymatous nephritis induced by a chill, accompanied by œdema of the lower limbs, then by suppression of urine, and finally, on the eleventh day of the disease, by uræmia of a convulsive and comatose form. After the first convulsive attack a hypodermic injection of two centigrammes of nitrate of pilocarpine was given; this produced neither sweating nor salivation. A second injection had equally negative results, but shortly after the third injection there was a redness to the extent of two centimetres around the puncture, then sweating over the body, beginning on the forehead, abundant salivation trickling out from the mouth; after several attempts, vomiting of a yellowish fluid. Half an hour after the injection the patient was passing water under her. The vomited fluid contained traces of ammonia. In the evening there was a fourth injection, followed by sweating and sialorrhœa. 60 grams of saliva contained traces of urea and .098 gram of albumen. 350 grams of urine contained .832 per cent. of albumen and 2.562 per cent. of urea. On the second day of this treatment (the twelfth of the disease) the patient had recovered her senses, and from this time the amelioration progressed; a fortnight afterward the urine contained no albumen.

Dr. C. E. Quire's Nasal and Ear Curette.

The accompanying cut represents a nasal and ear curette, devised by C. E. Quire, M.D., of Lynnville, Iowa.

The instrument is introduced with short bar straight, and after its introduction beyond the foreign body to be removed, the short bar is brought to the angle required, by the action of the index finger and thumb on the spring, as indicated in the diagram. The instrument is very delicate and well finished (nickel plated), and when we consider the difficulty often attending the removal of foreign bodies from the nasal and aural cavities there is no doubt but that this will be a useful addition to the surgeon's armamentarium.

The Atmosphere of Leadville, 10,500 Feet Above the Level of the Sea.

It has been asserted that the atmosphere of Leadville is poisoned by the smoke and gases from the numerous smelters, of which there are about twenty, in the neighborhood of the city.

Dr. Steinau, in a communication to the *Medical Record*, states that he has examined into the question, and comes to the conclusion that the amount of deleterious vapor, though large, is quantitatively insufficient to produce any poisonous effects. The gases from which danger is to be apprehended are those containing lead, sulphur, chlorine and arsenic. Estimating that each of the twenty furnaces around the city con-

sume thirty tons of ore per day, he finds that about ten ounces of chlorine, eighty pounds of sulphurous acid, and eighty ounces of arsenious acid would be given off every minute of the twenty-four hours. Most of the chlorine, however, unites to form solid chlorides; more than half of the arsenious acid fails to escape into the air, but is found in a solid condition in the speiss. The sulphurous acid is so diluted by the air that its presence is scarcely noticeable. The lead vapors are the most harmful, but their amount is small, and they can easily be prevented from escaping into the air. The conclusion, then, is, that the furnaces are not sources of danger from their poisonous emanations. This conclusion is confirmed by practical experience, as no cases of lead or arsenic poisoning have been found.

Dr. Steinau is of opinion that Leadville is in much greater danger from its neglect to care for the drainage of the city, and the disposal of filth. Nothing, he thinks, but the great natural salubrity of the place, with the high percentage of ozone in the air, has prevented an epidemic from occurring already.

Arsenic in Chorea.

According to *Bouchardat's Ann.* for 1880, we find that, from observations made in the service of M. Siredey, by M. Pomel, upon the treatment of chorea, the following deductions are made:—

1st. Of all the remedies employed in chorea, those which are the most rapid and sure are the arsenical preparations; particularly arsenious acid, which at once produces rapid amelioration of the symptoms, and brings about a speedy cure.

2d. Grave cases of chorea that have resisted other treatment yield, frequently with promptness, to arsenic.

3d. To obtain the full benefit of the arsenical treatment, it is necessary to administer the medicine in such doses as to produce, as speedily as possible, the constitutional effects or signs of arsenical saturation.

4th. Even in children affected with chorea, no hesitation should be felt in giving strong doses of arsenic, in order to reach the point of saturation quickly.

5th. Without denying the possibility of danger in the use of arsenic in the treatment of chorea, yet no case has thus far been recorded to establish the fact.

The preparation used by M. Siredey is Boudin's solution, containing 1 milligram ($\frac{1}{65}$th of a grain) of arsenious acid to 1 gram (15 grains) of solvent.

M. Siredey commences, in the case of a young and moderately vigorous subject, with ten grams of the solution a day, well diluted, and increases the dose each day by five grams. This dose is first diluted and then taken in divided doses during the day. Should vomiting or nausea occur the quantity must be diminished. For a child of eight or ten years, from two to four grams of the solution will be sufficient to commence with, increasing it daily by two grams.

Note by Translator.—As the solvent in Boudin's preparation is not given, Fowler's solution may be substituted. Its equivalent dose would be twenty minims daily, increased in the above proportion.

Correspondence.

A Case of Recurrent Fibroid.

Ed. Med. and Surg. Reporter:—

Ella S., a resident of Monroe county, single; age 23 years. Menstruated at the age of fourteen. Always enjoyed good health until the spring of 1879, when she consulted a physician, who pronounced her case prolapsus uteri. Shortly after, on the 23d of April, 1879, she consulted Dr. Hoffman, of Saylorsburg, Monroe county. Her symptoms at that time were sensations of pain in the pelvis, back and loins; also a leucorrhœa. On making an examination he found a gelatinoid polypus attached in the neck of the womb, about five inches long and one and a half inch in diameter, which he removed by torsion. In two weeks she had recovered from disease and operation.

On the 22d day of August she consulted Dr. Hoffman again, having a return of all her former symptoms. Physical examination revealed another growth, about half as long as the first and about three inches in diameter, of a more firm nature, which he also removed by torsion and she made a good recovery.

February 18th, 1880, she presented herself for the third time, with a return of all her former troubles, and on examination he found a tumor larger than the previous ones, dense and firm in character. He made two attempts to remove it, but failed. He then proposed consultation, and wrote for Dr. Seip and myself. We met in council on the 20th day of February, 1880; found the patient with symptoms as described by Dr. Hoffman; somewhat blanched, from loss of blood; retention of urine, from pressure of the growth on the urethra, requiring catheterization; considerable discharge, fetid in character, also pain during defecation. Physical signs by touch revealed a tumor filling the vagina, of a firm, elastic feel, more or less of a globular outline, and lobed sometimes by the pressure of an intersecting fascia or band. The physical signs

by speculum convinced us of the character of the tumor, viz., fibroid. Physical signs by sound revealed the capacity of uterus, and the existence of the growth and its attachment along the whole posterior portion of uterus and part of the fundus.

Treatment.—After having satisfied ourselves as to the character and extent of the tumor, we placed her upon a table covered with blankets and a pillow, in "Sims' position." Having introduced the large-size duckbill or Sims' speculum, and held it firmly in position, the loop of an ecraseur was thrown around the mass as high up as possible. Slowly and steadily it cut its way through the mass, the resisting fibrous tissue creaking under its pressure. Having done its work, we found a portion still remaining, which we removed by enucleation with the curved hysterotome and curved scissors. The hemorrhage was comparatively slight. After sponging the parts clean, the whole surface was penciled with full strength tinct. iodine. She was then put to bed and expressed herself comfortable. The after treatment consisted, constitutionally, in tonics, stimulants and nourishing alimentation, also ergot; locally, carbolized injections. In less than two weeks she was up and about.

On the 13th day of April, Dr. Seip and I were again called to see the case in council with Dr. Hoffman. Found the patient in the same condition again, the tumor having again returned, and was somewhat larger. We operated in the same manner, viz., ecruzement, and have here the specimen for your inspection. We removed a very large portion by enucleation again, which we did not preserve, as it had to be taken piecemeal. The after treatment was again the same, and the result favorable as to her getting up.

On May 8th, twenty-six days after the last operation, we were called for the third time to meet Dr. Hoffman. The tumor this time filled the vagina to its utmost, a portion protruding through the ostium vaginæ. The patient experienced considerable pain in the lower part of her abdomen; urination and defecation were interfered with; there was a very fetid discharge, together with the expulsion of large clots of blood. Appetite was poor, pulse about 120. The mass was of the same character, but softer, which was due to a partially decomposed condition. This time we removed the entire mass by enucleation; fortunately the os was dilated to admit the greater part of the hand, which facilitated operative procedure. There was considerable hemorrhage this time, and the operation being necessarily a slow and tedious one, she became weak. After having removed every vestige of the growth, tinct. iodine was again applied to the whole denuded surface, and she was then placed in bed. The pain was comparatively slight, considering the extent of the operation. The after treatment was again faithfully carried out by Dr. Hoffman, with such modifications as the exigencies of the case demanded, and in two weeks she was again up and about, visiting her neighbors, and went out carriage riding. Thus far the patient presented nothing unusual in her general appearance; she was plump, well developed and well nourished; she had a blanched appearance, which, of course, was due to the discharge and drain on her system; she presented no cachexia, neither any indication in the family history that would lead to any hereditary tendency to malignant disease. Unfortunately, a change took place in our patient, and the outbreak displayed itself in a bold and decisive character. The pulse became frequent and feeble, the appetite interrupted, the stomach irritable and nauseated, rapid emaciation, with pinched features, and the eyes sunk in their sockets, and the downward tendency was rapidly progressive. Death took place one month and four days after the last operation, and was evidently due to septicæmia, which manifests itself weeks and even months after surgical operations, and when the patient is apparently out of danger. There was no return of the growth. This was evidently a case of interstitial fibroid. A microscopical examination revealed nothing but a homogeneous mass of fibroid tissue, interspersed with connective tissue, having the unfortunate feature of recurrence after removal.

With reference to the propriety of removing uterine fibroids, there is a discrepancy of opinion among the medical profession. In 1853 the late Washington L. Atlee startled the profession by his method of heroically attacking uterine fibroids. His successes were numerous, and the ingenuity of his devices are deserving of the highest commendation; but it is only within the last six years that the profession have come to appreciate the great truths which he labored to establish. Meadows, of London, Thomas and Peaslee, of New York, and Goodell, of Philadelphia, have achieved splendid results in this direction, and made valuable contributions to our literature since Atlee led the way for us.

G. P. Fox, M.D.
Bath, Pa. W. H. Seip, M.D.

The Diploma Traffic.

Ed. Med. and Surg. Reporter:—

I enclose to you a clipping from the Pittsburg *Leader*, of June 10th, 1880, "About Doctors." The article dilates upon the expediency of the effort now being made in Philadelphia to suppress the traffic in bogus diplomas. The opinion which the *Leader* puts forth, that the effort will not be successful, I fully share with him. The *Leader* man hints at the root of the evil, and points out the only remedy that promises *permanent* success, when he says, "The only hope is that the people will learn to look less to diplomas, and more to the men themselves, in judging of doctors."

And again: "We believe that the best physicians would agree with us that perhaps the best way would be to let anybody call himself a doctor if he wants to, without a diploma at all, and then let the public themselves judge between the real doctors and the quacks."

On the same general principles that I condemn the "vigorous measures" "to destroy the cheap doctor shops" in your city, do I condemn the effort made to have a compulsory vaccination law enacted by our Legislature. You cannot force men, by legislative enactments or in any other way, to act above the level of their

intelligence, *persistently*, but they may be educated up to that level. In many respects the perpetuity of our form of government rests upon the individual responsibility of the citizen. It is important, therefore, that the citizen should be brought to a realizing sense of his individual responsibility, and if this object cannot be achieved in any other way, then let him have a sufficient amount of experience with cheap doctor shops, quack statesmen and quack doctors, smallpox, syphilis, free rum, etc., to cure him of his folly and bring him back to this realizing sense of individual responsibility. It is high time that we should all learn that legislative enactments are no specific for physical or moral evil. Such laws should be a reflex of the general intelligence or public opinion of the people. Such laws cannot successfully lead, but can only follow, and should be the index to, public opinion.

The remedy for all the evils that afflict society, as well as the body politic, is comprised in the one word, *education;* all else is quackery. Law is force; education is liberty. Force is not the battle cry of those who win the victories of the nineteenth century; much less will it be so in the twentieth. Education is the still, small voice that is silently speaking peace to our conflicting theories, and slowly but surely striking the shackles of ignorance from our minds.

As a means of advertising those great questions of reform, and thus bringing them prominently before the people, your efforts to suppress cheap doctors and other evils by legislative enactments and their enforcement may be commendable, but as to their being, in the long run, successful measures for reforming those evils, it is my opinion they will prove a failure.

Those who are such earnest advocates of legis lative enactments to reform or suppress the many evils that afflict society or the State too often forget that this is not a patriarchal government, such as existed among the ancient Hebrews. Neither is it a paternal government, such as now exists in Germany, but it is a republic, based upon the suffrage and individual rights of the people. I think that, aside from education, the best way to suppress quack doctors would be to suppress quack legislators, by voting only for men who fully comprehend what can and what cannot be accomplished, in the direction of reform, by laws.

Now, Mr. Editor, as you have so ably advocated the compulsory plan of suppressing those evils, in your editorials, I hope you are willing to give space in your valuable REPORTER for the presentation of the other side of the question.

H. NYE, M.D.

Enon Valley, Pa., June 17th, 1880.

[We cheerfully give space to the above, and while we fully agree with our correspondent that the public should be at liberty to choose their own doctor, yet we believe it would be well if those from among whom to choose were all intelligent and well educated physicians. Where human life and health are at stake the Government should always exercise a supervising authority. Who would, for instance, think of manning an ocean passenger steamer with officers and crew consisting of shoemakers and tailors? And yet the average passenger has no means of ascertaining, before embarkation, whether the officers, sailors and engineers are competent men or not; and to make a passage in order to test them might be a dear experiment. And so it would be if the public were to test every idiot or charlatan who might choose to call himself a doctor.—ED.]

NEWS AND MISCELLANY.

Correction.

On page 549, second column, Dr. G. H. Lathrop's address is given as Wurtsboro, N. S., which should read *Wurtsboro, N. Y.*

International Otological Congress in Milan.

The members of the First International Otological Congress, held in New York, in 1876, decided that the second Congress should take place in the same city in which the International Ophthalmological Congress should meet. As the Ophthalmological Congress is to meet in Milan, Dr. Voltolini, of Breslau; Dr. Moos, of Heidelberg; Dr. Politzer, of Vienna; and Dr. Loewenberg, of Paris, have decided that the International Otological Congress shall also meet there, from the 6th to the 9th of September, 1880. A local committee has been formed, consisting of Professor Rossi, of Rome; Dr. Sapolini and Dr. Restellini, of Milan. Gentlemen who intend to attend the Congress are requested to communicate with Prof. Moos, at Heidelberg; and those who intend to read papers are also requested to inform him of the fact.

The Vivisection Question in Germany.

The *Medical Times and Gazette* for June the 5th, 1880, informs us that Professor Virchow, speaking the other day at the Committee to which the petitions to the German Reichstag against vivisection were referred, observed that the agitation was not only against vivisection, but endangered the entire experimental method. As, heretofore, Harvey's discovery of the circulation only became possible by means of experiments and researches made on living animals, so at the present time they are necessary in physiology, pathology, and pharmacology, neither research nor instruction being able to dispense with them. Many branches of science could not be carried on without them, and especially the physiology of the nervous system. In England, the laws against vivisection have done so much mischief, he added, that since their enactment no physiological work of any importance whatever has been accomplished. The Committee resolved to propose an order of the day, declaring that, in the interests of physiological inquiry, it is indispensable that vivisection should be carried on in educational institutions.

An Extenuating Circumstance.

A chemist's assistant was recently charged, before the Correctional Chamber of Paris, with causing the death of a man by misreading a prescription. The doctor, whose writing is very clear, ordered eight drops of laudanum, which the assistant carelessly read as eight grams, or about a quarter of an ounce. The overdose naturally killed the patient, and the court sentenced the prisoner to three months' imprisonment. The defendant's advocate very ingeniously urged as an extenuating circumstance that if the mistake had cost the deceased his life, it had at least provided him with a painless death.

Miscellaneous Articles Found in the Stomach of an Ostrich.

An ostrich, long on exhibition at Rome, having been suffocated by thrusting its neck between the bars, there were found in its stomach four large stones, eleven smaller ones, seven nails, a necktie pin, an envelope, thirteen copper coins, fourteen beads, one French franc, two small keys, a piece of a handkerchief, a silver medal of the Pope, and the cross of an Italian order.

Personal.

—Dr. C. Pollock, of Donnellsville, Ohio, has removed to Muncie, Ind.

OBITUARY NOTICES.

—Dr. W. Kent Gilbert, Coroner of Philadelphia, died at midnight, between June 28th and 29th, at his home, southeast corner of Ninth and Pine streets. He had been ill for about ten days, with typhoid fever. On Sunday he grew so ill that Dr. Packard, his physician, who was at Cape May, was sent for to attend him. He grew worse on Monday, and yesterday it was seen that death was inevitable.

Dr. Gilbert was a graduate of Jefferson Medical College, and was a physician having a very large practice. He was the son of Dr. W. Kent Gilbert, celebrated in his time, who lived years ago in an elegant mansion on Arch street below Eighth. In 1877 he was elected Coroner. He was a man of high professional attainments, and one of the most noted bibliomaniacs in the country. His collection of rare books and pamphlets is large and valuable. He visited all the great book sales, and continually added to his library. He was also possessed of a very fine collection of autographs and rare documents.

—Dr. James A. McCrea, of this city, committed suicide on the 22d of June, at his residence, No. 2004 Delancey Place, by severing the jugular vein and carotid artery with a razor, while taking a bath.

Dr. McCrea was born in this city in 1812. He was the son of John McCrea, for many years an East India merchant, who died leaving his son an ample fortune. At the age of 21 the Doctor was graduated at the Pennsylvania University, but he never practiced his profession, though he was connected, when a young man, with the Friends' Insane Asylum, Frankford, and the Blockley Almshouse. In 1859 he was appointed a member of the Board of Health, by the Court, and he has been reappointed every three years since that time. His term would not have expired until 1882. He acted as President of the Board for some years. He was also one of the Commissioners appointed to superintend the erection of the municipal hospital, which was dedicated in 1865. In all his public life he was independent to a degree that made him a terror to his associates, though his integrity, which was of the strictest kind, was never questioned. The disease which it is believed caused the aberration of mind that led to his death was of some years' standing. He lately became very much depressed, and for some time had not attended to his official duties. Only a few days ago he complained to Clerk Troth, at the Board of Health office, that he felt himself gradually breaking down. This seemed to prey upon his mind and caused the deepest despondency. The act which ended his life is not thought to have been premeditated.

QUERIES AND REPLIES.

In reply to query of Dr. H. W. M., of Iowa, numerous correspondents, both physicians and druggists, have sent us the following formula for Tully's powder:—

℞. Morphiæ sulph., partem j
Pulv. camphoræ,
Pulv. glycyrrhizæ radicis,
Cretæ prep.,
Sacch. albi, each partes xx. M.

N.B.—Some leave out the sugar, which, of course, alters the dose.

Another sends the following formula:—

℞. Cretæ preparatæ. gr.viij
Ipecacuanhæ, gr.j
Morphiæ sulph., gr.⅛–¼
Camphoræ, gr.ij. M.
Ft. pulv. No. j.

Dr. C. G., of Connecticut, writes: In the REPORTER, of October 11th, 1879, Dr. Coover described a silicate of soda jacket for spinal disease. I thought it would be better than the plaster, and tried it on the first case that offered, but have not succeeded in making a good jacket. The silicate of soda which I have will not stick, and the patient's sweat softens it. Will some one be kind enough to tell me how to use the silicate, in your Answers to Queries.

Dr. J. M. B., of Pa., writes: I should like to have some advice upon a troublesome case of orchitis. I have used lead water and laudanum, iodoform and tincture of iodine, with but little effect. I am somewhat disappointed in the above remedies, as I have been using them successively for five weeks. Will some one be kind enough to suggest something that will help me through with the case.

Subscriber, Wis.—We do not know.

MARRIAGES.

WYSONG—NEWBOLD.—On June 17th, 1880, at the Church of the Saviour, West Philadelphia, by Rev. Charles Newbold, assisted by Rev. W. W. Farr, D.D., D. Preston Wysong, M.D., of Harford county, Md., and Rebecca M., daughter of the late Charles Newbold, of this city.

DEATHS.

MORRIS.—On Monday, June 14th, at his residence, Pelham, Westchester county, N. Y., Dr. Richard Lewis Morris, in the 75th year of his age.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1219.] PHILADELPHIA, JULY 10, 1880. [Vol. XLIII.—No. 2.

Original Department.

Communications.

REMARKS UPON THE TREATMENT OF SICK STOMACH OF PREGNANCY.

Read before the Lancaster City and County (Pa.) Medical Society, at its meeting held at Columbia, Pa., April 7th, 1880,

BY W. STUMP FORWOOD, M.D.,
Of Darlington, Harford County, Md.

Mr. President and Gentlemen:—Compared with some of the conspicuously technical titles of the subjects placed upon your programme for consideration to-day, the malady which we have selected for presentation to your notice is most homely and common-place. This fact, indeed—its homeliness and its frequency—together with its illy understood and little considered pathology, constitutes its strongest claim upon our serious attention. Superadded to the physical distress which constant nausea occasions, how can we estimate the mental suffering endured by the young and timid bride, whose pregnancy is thus advertised to all her acquaintances, perhaps before she has completed the round of her wedding entertainments!

However acute or lasting her suffering may be, or however exhausted and prostrated the patient may become, instead of receiving words of kindness and sympathy from her friends, she is greeted only with rude jokes and unsympathetic smiles. And her physician even, if she thinks it worth while to apply to him at all, will, in nine cases out of ten, make her a jocular reply, and tell her that this trouble will all pass off after a while, at furthest, at the expiration of nine months!

This, as we all know, is the common experience of women who suffer from the sick stomach of pregnancy; they get neither sympathy from their friends nor relief from their medical attendant. The physician covers his ignorance under a coarse joke, or under some inefficient placebo. Ladies coming under our professional care have frequently expressed surprise upon being told that there was a remedy for this wretched sickness; they having been informed by their old family physician, in former pregnancies, that medical treatment was unavailing for the relief of their complaint, that the sickness was a condition inseparable from pregnancy, and "must run its course."

Some women, it is true, altogether escape this sickness in their pregnancies, but the majority suffer with it in some degree; and in a few cases, occurring in peculiarly delicate and nervous females, they are kept prostrate upon their beds for weeks and months at a time, and reduced in flesh almost to a shadow.

In the entire catalogue of ills that afflict the human family we can recall none not immediately dangerous to the existence of life so annoying, so embarrassing, and so distressing to the sufferer, as the sick stomach of pregnancy. This malady conjoining, as it does, the mental with the physical distress, the natural temperament of the patient undergoes a radical change; the habitually kind and placid disposition of the individual becomes impatient, irritable, morose and petulant. Everything annoys her, and everybody who comes in contact is apt to be annoyed by her. We can conceive of but few obligations resting upon us as physicians, apart from the actual aversion of impending death, more imperative in their demands upon our talents and

moral obligations than that of relieving the mental and physical sufferings incident to pregnancy. This is a subject that interests the entire human family; our mothers, our wives, our daughters, the female community at large, through whom the race is propagated, and to whom our own existence is due, must all undergo the pains and perils of pregnancy. These sufferers, therefore, have a peculiar claim upon all the skill and sympathy at the command of the physician.

Early in our professional career the want of some reliable prescription for the relief of the sick stomach of pregnant women was pressingly and painfully felt. Our medical teachers at college dwelt very briefly, indeed, upon the subject, and after entering upon practice, we looked in vain to the books for instruction; they were comparatively silent, as, indeed, they yet are, upon this affection. Upon one occasion, we believe in the year 1856, while we were lamenting to a medical friend, now deceased, our utter want of a proper remedy for "morning sickness," as it is usually termed, he rejoined that a certain physician of distinction, whose name we have forgotten, had earnestly recommended a prescription, which was originally suggested, so far as he knew, by Professor George B. Wood, in the *United States Dispensatory*.

Every other treatment having failed in our hands, although we had tried various so-called remedies suggested by the medical journals, we were quite ready to grasp at anything that held out the least promise of success. The results were almost magical; far in advance of our expectations. Every case was relieved more or less completely; and those who persevered in the use of the remedy for a few weeks were entirely cured.

In reference to the remedy itself, we have no new medicines, under high sounding and unpronounceable names, to introduce to you; they are old, familiar, and long-tried pharmaceutical friends, their novelty consisting only in the new *rôle* they now play. The medicine that we rely upon for the cure of the sick stomach of pregnancy, is an infusion of columbo, ginger, and senna.

The details of its preparation and administration will be given as we proceed.

We have regularly prescribed this remedy through a period extending over nearly the quarter of a century; and with the most gratifying results.

We have verbally communicated the prescription to a great number of medical friends residing in various parts of the country, and in all instances where they have reported their experience the same general success resulted. Hoping still further to extend the knowledge of so simple and so efficient a remedy, we prepared a brief paper on the subject, and read it before the Medical Society of Harford County, Maryland, at its regular meeting held August 11th, 1868, detailing our then twelve years' experience with the remedy. The chief inducement that led to the preparation of that paper was that of supplementing vague theories that were being published with something more practical and reliable.

On February 22d, 1868, there appeared, in the London *Lancet*, an article of considerable pretensions, professing to be a *résumé* of the various and most reliable medicines prescribed for this affection by the leading physicians of the chief hospitals of London. The views of the following distinguished teachers were quoted:—Dr. Greenhalgh, of St. Bartholomew's Hospital; Dr. Graily Hewitt, of the University College Hospital; Dr. Playfair, of King's County Hospital; Dr. Murray, of the British Lying-in Hospital; Dr. Meadows, of the Hospital for Women, Soho Square, and other well known physicians of the period. This article was copied into the Philadelphia *Medical News and Library* for April, 1868.

In our paper, the preparation of which, as before stated, was suggested by these views, we quoted the leading points of treatment advised by these authorities; but, really, we do not now regard them as of sufficient value to occupy your time with their reproduction here. Those interested may consult the original papers above named.

Our paper was afterward published in the first number of the first volume of a small medical journal started in Baltimore, entitled *The Medical Bulletin*, and edited by Dr. Edward Warren. This journal, and especially the first number of it, had a very limited circulation, and we believe survived only one or two years. Although it may be said that our paper was "published," we feel sure that the journal containing it reached but a very few readers.

Twelve years having elapsed since this limited publication, it has frequently been upon our mind within the last two or three years to reproduce it and give it a wider circulation. Therefore, when a member of your committee applied to us, two or three weeks ago, for some material for presentation to your Society at this meeting, we could think of nothing more practical or appropriate to the occasion than to offer you our experience in the treatment of the sick stomach of pregnancy.

Notwithstanding the extremely limited circulation of the *Medical Bulletin*, our article did not escape the vigilant eye of Dr. George H. Napheys, of Philadelphia, who at the time was engaged in the compilation of his work on "Modern Therapeutics," which was first published, we believe, in the year 1869 or 1870. He copied the prescription as a remedy for the complaint in question, without according credit to any one for the suggestion. This plagiarism was so glaring—for he had used a sufficient number of our words in connection with the prescription to place its quotation beyond all doubt—as to bring forth from our friend, Dr. W. W. Virdin, of Harford county, a forcible protest. Dr. Virdin's explanation of the source of the prescription was published in the Philadelphia MEDICAL AND SURGICAL REPORTER, in or about the year 1870.

Dr. Napheys essayed a feeble rejoinder through the pages of the same journal, to the effect that he gathered his information, with an omnivorous appetite, from all attainable sources—which none would object to, provided he made the proper acknowledgments—but he neither confessed the plagiarism, claimed originality, nor indicated the source of his information regarding the prescription. Death having claimed Dr. Napheys as one of its victims, we would not, if we could, say more.

Of late years many suggestions have been made through the medical journals as to the treatment of "morning sickness;" scarcely a month passes that we do not meet with a paragraph or two upon the subject; yet in no instance, except in that of Dr. Napheys, have we found any mention of our prescription. Within a few weeks we have read in one of the journals where a writer announced that he had cured a case by the dilatation of the os uteri. This proceeding we should regard as extremely hazardous to the pregnancy, to say the least. Since the uterine speculum has been brought into such general use, we fear that serious inroads have been thoughtlessly, and in many instances unnecessarily, made upon those delicate sentiments of modesty which we admire so much in woman. But even though the dilatation of the os uteri should prove remedial for this affection, yet how much more agreeable to the feelings of both patient and physician to have at command an efficient remedy for administration per orem.

About fifteen years ago, as correctly as we can remember without referring to the authorities, the oxalate of cerium was introduced to the profession, with a great flourish of trumpets, as an unfailing remedy for the sick stomach of pregnancy. The journals teemed with its virtues for several years, but like nine-tenths of all the new remedies in medicine, this preparation seems to have fallen into disuse. The results from its use in our hands were far from satisfactory, though we confess we never experimented with it to any very great extent, for the very reason that we already had a simple and reliable remedy in hand. The original suggestion, referred to previously, as to the application of this prescription in the malady under consideration, by Dr. George B. Wood, in the "United States Dispensatory," is expressed in the following vague and incidental language, and perhaps has not impressed the mind of one reader in a thousand with its connection with this subject. Under the head of "Columbo," and more technically, "Calumba," Professor Wood uses the following language: "It has been highly recommended in vomiting unconnected with inflammation, as in the sickness of pregnant women. It is frequently administered in combination with other tonics, mild cathartics, and antacids. The remedy which we have found most effectual in the permanent cure of a disposition to the accumulation of flatus in the bowels is an infusion made with half an ounce of columbo, half an ounce of ginger, a drachm of senna, and a pint of boiling water, and given in a dose of a wineglassful three times a day."

To make the prescription clear to the eye of the reader at a glance, we place it in regular form, as follows:—

℞. Rad. columbo contus.,
Rad. zingiber., " āā ℥ ss
Fol. sennæ, ℥ j
Aqua bullient., ♎ j
Infus. M.

SIG.—Take a wineglassful before each meal.

It will be seen from this quotation, that Professor Wood, one of the most careful and accurate of writers, only makes a passing reference to the value of this prescription in the sickness of pregnancy; evidently attaching but little importance to it, simply stating that it had been recommended in such cases, but did not think it worth while to state by whom it was recommended. He chiefly dwells on its value in dyspepsia, constipation and flatulence, in which complaints he has found it an effectual remedy. This is all the information regarding the use of this prescription in the sick stomach of pregnancy that we have ever obtained, except what we have derived from our own experience with it, and from the experience of dozens of our fellow practitioners to whom we have communicated the recipe.

For a time we used these medicines in a powdered state, but finally abandoned it in that form, because of the "mushy" character of the infusion, which was disagreeable to the patient and difficult to filter with ordinary appliances. Later in practice, we prescribed the fluid extracts of each of the three ingredients, but for some unexplained reason they did not appear to act so efficiently; therefore, we have now returned to the original recipe, which was simply to contuse the roots, and directing that each dose be filtered through gauze when taken, and immediately after pouring off each dose we direct that the vessel containing the infusion shall be well stirred or agitated, to facilitate the extraction of the virtues from the herbs. We have also found by experience, that when the infusion has been about half used, it may be filled up to the original quantity by adding half a pint of boiling water, when the second preparation will be nearly or quite as strong as was the first half. In warm weather it is better to prepare a smaller quantity at a time, and keep it in a cool place. Also a small portion, two or three tablespoonfuls, of brandy or gin, may be added with advantage to the infusion, for its stimulating effects upon the patient, and for its value in preserving the infusion from the souring process in hot weather.

In some cases, attended with unusual acidity of stomach, we add half a drachm of carbonate of magnesia to the recipe. Constipation of the bowels nearly always exists in this sickness; but should the bowels, on the contrary, be relaxed, we omit the senna.

We are in the habit of prescribing two parcels of the recipe for the patient to take continuously, mixing one at a time, and making the addition of water referred. This quantity is sufficient in mild cases; of course, it must be continued longer if necessary. There appears a tendency on the part of the complaint to return in the course of three or four weeks after the conclusion of the first treatment. By then using one or two pints more of the infusion, the patient will be almost invariably cured of her sick stomach.

When the complaint is at all violent, it is better for the patient to take the morning dose, and afterward her breakfast, in bed, and not to rise until at least one hour after eating.

Patients rarely present themselves for treatment until they are very much exhausted from this sickness. They are weak, pale or sallow, emaciated, constipated, nervous, and express themselves as feeling wretched generally. In the columbo and ginger we have the tonic and stomachic so much needed, and in the senna the gentle laxative; all of which being combined, mildly stimulates to healthy action the disordered stomach, liver, kidneys and bowels. The bitter taste of the medicine, so objectionable at first to the patient already so extremely nauseated, soon disappears upon the establishment of healthy digestion and return of natural appetite. The morbid mental condition of the patient also clears up and disappears, as does the pale and sallow complexion. Of the many patients to whom we have prescribed this medicine, we remember but one who persisted in asserting that she derived no benefit from it whatever; and in her case it was prescribed in two separate pregnancies, with the same report. This patient always referred in strong terms to the extremely bitter and unpleasant taste of the medicine; and as her sickness was not at any time so extreme as to confine her to bed, we had our suspicions that she did not persevere in the use of the remedy as we directed her to do.

We may safely say that three-fourths of our cases have been absolutely cured under this treatment, and the remainder so much benefited as to enable them to discontinue the treatment after two or three weeks' use, without any serious inconvenience subsequently. Every patient to whom we have administered this prescription has been so far benefited as to leave her bed and to attend to her usual duties. We have known of patients, without such treatment, who were compelled to remain in bed for weeks at a time, as their only relief from distressing nausea.

In more than one case that has applied to us for treatment, wherein sick stomach was the prominent symptom, without any explainable cause for its presence, and where, if pregnancy existed, there were strong motives for its concealment, we have repeatedly verified our suspicions, without the knowledge of the patient, by the successful employment of this infusion. Even in cases where there were no motives for such concealment, the patient's experience being so different from that in former pregnancies as to mislead her in regard to her present condition, we have been able to satisfy all concerned of the fact, by the prompt relief afforded by this remedy. It may therefore be regarded as possessing great diagnostic value, apart from the curative, in cases of suspected pregnancy.

In conclusion, we will quote the last paragraph in our previously published paper on this subject, with the remark that the experience of the twelve years that have since elapsed has confirmed to an equal degree the experience of the twelve preceding. The following is the language referred to:—

"As before stated, we have been in the regular practice of administering this infusion to all cases of 'morning sickness' that have come under our charge during the last twelve years, numbering perhaps two hundred or more; and such has been our uniform success, that we will remark, in closing, though the expression may appear extravagant, that we regard the columbo, ginger and senna infusion as much entitled to the character of a specific in the treatment of the sick stomach of pregnancy, as quinine is in the treatment of intermittent fever.

OPHTHALMOLOGICAL CONTRIBUTIONS.

BY P. D. KEYSER, M.D.,

Surgeon, Wills Eye Hospital, Philadelphia.

Duboisia.

When a new substance in materia medica is brought before the profession it immediately finds a number of advocates, who, in all their experience and very numerous experiments with it, have additional testimony in its favor to add.

In this way many an article receives a reputation, and is much used in the profession, without any doubt of its reliability, taking for granted that from its number of advocates there can be no doubt of its efficacy; and then because those who have written upon its action have done so with such zeal and earnestness, which has given the impression that it is and must be perfect, and can be thoroughly trusted at all times and on all occasions.

Since the introduction of duboisia as a mydriatic in ophthalmic medicine, many have written thereon, in this country as well as in Europe; and all of the experience, as given, places it as always thoroughly reliable and more effective and rapid in its action, when instilled in the eye, than atropia, even in much weaker solutions. None, however, mention any irregularity of its action; thus giving the impression that it is at all times sure and certain in its action, in all cases, whether in strong or weak solutions.

Knowing that nothing is perfect in this world, I determined to test this reliability of its action on the pupil and accommodation, and used it in one hundred cases to dilate the pupils for special ophthalmoscopic examination, as well as to paralyze the accommodation, in correcting defects of refraction.

My experience in this thorough trustworthiness has been so different from former writers, that I feel it a duty to lay it before the profession, so that they may know that it is like all other articles, having a regular and irregular action at times, and upon certain individuals.

Of the hundred cases in which it was used, in ninety of them my experience agrees with the given data of those who have written about it. Its action was much quicker, more energetic, and passed off in much shorter time than atropia. In ten of the cases, however, it acted very irregularly, as follows:—

Miss Mary J. B., age 24. Vision, $\frac{20}{xxx}$. Ophthalmoscopic examination. Hypermetropia 3D. After the instillation of a drop of a solution of sulphate of duboisia, two grains to one ounce, in the eyes, the pupils were dilated ad maximum, and accommodation thoroughly paralyzed in twenty minutes, with vision reduced to $\frac{6}{c}$. While examining her the accommodation and pupils began to change, and in less than an hour from the time of the instillation the pupils were normal, with free, prompt action, and the paralysis of accommodation had passed entirely away. Vision was again $\frac{20}{xxx}$, and she could read readily, for awhile, Snellen 1½ at twelve inches.

Returning the next day, the same solution was used, and the instillations made three times within an hour, without the effect of paralyzing the accommodation, or of dilating the pupils ad maximum. The thorough effect desired was only gained after the use of a four-grain solution several times.

Henry V., age 26. Congenital dislocation of the lenses. It being necessary to dilate the pupils, to examine the eyes carefully, I instilled a half-grain solution in the eye, thinking I would get the pupils large enough in a few minutes. Four instillations of this solution in half an hour did not dilate the pupils in the least. After waiting one hour I used a one-grain solution, which had the desired effect in half an hour.

Miss J. C., age 18. Ophthalmoscopic examination. Compound hypermetropic astigmatism. A two-grain solution of duboisine instilled into the eyes. Pupils well dilated and accommodation completely paralyzed in thirty minutes. The action did not, however, pass off before the tenth day after.

Henry H., age 56. Ophthalmoscopic examination. Mixed astigmatism. A two-grain solution was used, to paralyze the accommodation, but it did not have the desired effect until used several times a day for two days. The action did not pass off until the seventh day.

Mrs. R. C. H., age 45. Compound hypermetropic astigmatism. A drop of a one-grain solution was instilled into the eyes at 15 minutes before 11 o'clock. Not the least sign of any

action at 11½ o'clock. Used now a two-grain solution; at 12 o'clock a partial dilatation of the pupil and slight change in accommodation. Instilled a three-grain solution, and at 12½ o'clock complete paralysis of the accommodation was not attained. It was not until 1 o'clock that the desired effect was achieved.

Thomas M., age 35. Mixed astigmatism. A one-grain solution instilled four times in half an hour, without any perceptible action. A two-grain solution used twice in half an hour succeeded. The action did not pass away until the seventh day after.

Mr. R. M. C., age 52. Compound hypermetropic astigmatism. At 10½ o'clock A.M. a drop of a one-grain solution of duboisine was instilled into the eyes, followed in fifteen minutes by another instillation. At 11 o'clock no dilatation of the pupils; they acted promptly under the influence of light; but it was found that the accommodation was affected. At this time a two-grain solution was used, and the instillations made twice in half an hour. At 11.40 o'clock the pupils were dilated ad maximum and accommodation paralyzed. The action did not pass off until the eighth day after.

P. W. S., age 14. At 9 o'clock a two-grain solution instilled. No action at 10 o'clock; again introduced, and no action at 10½ o'clock. A four-grain solution was now used, and it was not until 11½ o'clock that the required effect was attained. The action did not entirely pass away until the tenth day after.

Mr. C. B., age 68. Pupils naturally very much contracted. Desiring to get a good view of the fundus, I instilled a half-grain solution, for the purpose of slightly dilating the pupils. No change in the size of the pupils after waiting twenty minutes. Half-grain solution again used. No effect in twenty minutes more. A one-grain solution was now dropped in the eyes, which had no effect after waiting again twenty minutes. Determined to test the duboisine in this case, I now used a two-grain solution, and after waiting half an hour the pupils were dilated about twice their natural size, and in one hour about 4 mm. diameter. This width they remained for three days, then reduced to 3 mm., at which size they have remained ever since.

Mr. S. B., age 21. Ophthalmoscopic examination. Compound hypermetropic astigmatism. A two-grain solution did not paralyze the accommodation after instilling it twice in forty minutes. A four grain solution was used, and it took a full hour before the proper effect was obtained. The action did not pass off until the tenth day after.

In 90 per cent. of the cases the action was prompt, and really much quicker than with atropia, requiring, at the furthest, but half an hour to reach the desired effect of complete paralyzation of the accommodation. The action passed off in two to four days. In 10 per cent. the action was irregular and unreliable, as shown in the cases cited.

In comparing it with atropia, in my hands I find it no more reliable, only a little quicker in its action in a majority of cases. I have had many cases in which atropia, of a four-grain solution, has completely paralyzed the accommodation in forty minutes. Atropia, although a little slower in its action and a little longer (eight to ten days) passing off, has always been very reliable with me.

In cases after cataract operation, where some inflammation of the iris has set in, from either contact with the torn capsule or remaining cortical mass, and prompt action is required, I have found duboisine much preferable to atropia. Also in cases where atropia creates a conjunctivitis, I have found duboisine in a one grain solution to be readily received without irritation.

Of the toxical effect of duboisine I have had no experience. In none of my cases has such been perceived. I do not think there is any danger, if the proper care is taken in the instillations in the eye by the surgeon using it, but under no circumstances would I prescribe it as we do atropia and let the patient use it at home. In using it I am careful to draw the lower lid down at the outer canthus, so as to form a pocket, into which I drop the solution; at the same time, while still holding the lid in this way for a moment, I place the point of a napkin in the inner canthus, to absorb all the surplus as soon as I let go of the lid and permit it to adjust itself. In this way the napkin takes up that which would pass through the canaliculi into the tear duct and down into the throat. It will thus be seen that duboisia, although a very active and efficient remedy in most cases, is not to be always positively relied upon in its promptness of action and the rapidity with which it passes off.

Leptothrix.

In Part I, vol. III, of the "Archives of Ophthalmology and Otology" (1873), Dr. Gruening describes a case of leptothrix in the upper canaliculus, and as being the second of the kind on record, Schirmer, of Greifswald, having published the first, demonstrating the existence of this fungus in that position. Del Monte, in 1874, reported a case where seventeen little leptothrix concrements, from the size of a powder grain to

a hemp seed, were found in the upper canaliculus of a patient. In the lower canaliculus it has been more frequently observed. v. Græfe reports ten cases; Forster, one; Bugier and Hirschler, each, one. It will be seen, from the really few cases that have been as yet reported, that the existence of this fungus in the canaliculus belongs to the class of rarities in ophthalmic practice, and as I have seen nothing later in the report of such cases than those above mentioned, I feel at liberty to present the following three, which have come under my observation:—

On November 12th, 1874, Mrs. D. D. M., age 62, of Burlington, N. J., was brought to me with double cataract, for operation. In the right eye, which was first blind, there was considerable conjunctival catarrh and epiphora, which she said had been there for some time. There was intumescence of the caruncle and semi-lunar fold; a considerable cylindrical swelling along the course of the lower canaliculus, and a very large, round, crater-shaped puncta, with a whitish rolled edge. On pressure a viscid, yellowish, pus-like substance came out of the puncta, but the swelling was not reduced. Remembering v. Græfe's, Forster's and Gruening's accounts and descriptions of their cases, I judged that I had such an one here, and so informed my patient, who consented to its removal before the operation on the cataract.

With a Weber's canaliculus knife I slit up the canaliculus, and immediately was exposed a large mass of an opaque yellowish concretion, of a soft consistence, with uneven surfaces, which was removed by a Daviel's spoon. The canal was enormously distended. In a few days all inflammation in the eye passed away, and the cataract was successfully removed. After the removal of the concretion it was carefully examined. It was broken into pieces, and found to contain opaque chalky particles, which were removed by dilute hydrochloric acid, and then, under the microscope, the leptothrix elements were plainly and clearly seen.

I cultivated some in glycerine, as Gruening did, and derived the same result, viz: "The next day a delicate, whitish, gossamer-like zone formed around the particles, which increased considerably in twenty-four hours, extending to the surface of the glycerine, forming thereon a lightish-green layer, the microscopical examination of which demonstrated filaments of penicillium and pencil spores.

J. C., age 36. Came to me June, 1877, seeking relief for an inflammation of the right eye, from which he had been suffering for nearly a year, and for the past month it had given him much more trouble than formerly.

The whole of the conjunctiva was more or less inflamed and thickened, but the upper canaliculus was very much swollen, and the puncta enlarged and crater-shaped. On pressure only a little yellow pus-like substance came out.

Suspecting leptothrix, I slit the upper canaliculus with a Weber's knife, and in the largely distended canal four small, yellowish, round particles, about the size of a millet seed, were seen, which were removed, and on examination, as in the previously mentioned case, leptothrix elements were found.

Miss Maggie A., age 21, came to my clinic at the Will's Eye Hospital, March 6th, 1880, for treatment of a tumor growing on the lower lid of the left eye. There was considerable inflammation in the caruncle and semi-lunar fold. The lower canaliculus was largely swollen, and just behind it there was a tumor projecting, like a meibomian cyst; at the same time the puncta was very much enlarged, and out of it was a fleshy, wart-like growth. On pressure a little viscid fluid came out.

My impression was that it was a meibomian cyst, that had formed near the canaliculus, and had opened into the tube. To get at it properly I slit up the canaliculus, and at once there presented to view a large, yellowish, opaque mass, the size of a hemp seed. It was carefully removed, and on examination I found it to be a concretion of leptothrix elements, resembling exactly the first case I report above. In a few days all the inflammation passed away, without any other treatment.

The human body is infested with many parasites, animal and vegetal, which either crawl over the surface, burrow beneath the skin, nestle in the viscera, or propagate their kind in every part and corner of the body. Each has its special or favorite place of domicile; and at times it is transported or planted unconscionably from one part to another.

Of the vegetal parasites which grow and multiply on the human frame, the leptothrix buccalis, a form of penicilium, is extremely general in the mouth; being found in the saliva and the soft, cheesy-like accumulation on the teeth, which eventually hardens into the concretion called tartar.

In accounting for its origin, it is reasonable and natural to infer that it is not from spontaneous generation, but that the germs have been introduced into the mouth either by the air, water or food. The air, water, food, and

the earth are more or less alive with myriads of microscopical beings, which can readily be introduced into any part of the body, there to remain as a place of habitat.

Now the question would naturally arise, how did this fungus get into the canaliculus? By the simple and common practice of moistening the end of the fingers with the saliva and rubbing it on the edges of the eyelids if they itch or burn, is, no doubt, the manner and method of transporting the germs from the mouth to the eye, which have eventually formed a place of habitat in the canaliculus, and there multiplied.

All of the above described cases informed me that they had been in the habit for a long time of frequently moistening the finger in the mouth and rubbing the edges of the lids therewith. Particularly so in the morning, on rising from bed.

Congenital Band of the Iris Dividing the Pupil into Equal Halves.

Miss Bessie McC., age 26, came to my clinic May 27th, 1879, to see if anything could be done to improve the sight of her left eye. On examination it was found that the pupil was divided in half by a broad band running across from margin to margin of the iris, at an angle of 110°. This band was 1½ mm. wide, of the same thickness, color (bluish gray) and continuous structure of the iris. It was entirely different from any of the persistent pupillary membranes that we have seen. On the instillation of atropia in the eye it appeared to stretch considerably. She said that she had never suffered from any inflammation in the eye, nor were there any points of adhesion to the capsule to be found. The iris was perfectly free and movable at every point except where held in check by this band.

On June 7th I admitted her into the hospital for operation, as I proposed to try to remove this band without destroying the continuity of the pupil.

After the patient was anæsthetized, a small incision was made at the lower and inner quadrant of the cornea, through the sclero-corneal junction, as far back as possible, to prevent prolapse of the iris. A delicate pair of iris forceps were introduced through the incision, passed up in the anterior chamber to the upper line of the pupillary margin and attachment of the band, where it was grasped in its whole breadth and pulled down so as to tear it loose from this point. This being accomplished, it was drawn out of the corneal incision and cut off just at the pupillary margin. The iris, which came out of the corneal incision, was replaced by the spoon and a solution of pilocarpine (4 grs. to the ounce) dropped in the eye. A bandage was put over the eye and the patient put to bed. No inflammatory condition set in after the operation; and the pupil became round, as in the normal condition. The action of the iris has been perfect ever since.

Hospital Reports.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

CLINIC OF PROF. JACOBI, APRIL 14, 1880.

Infantile Constipation.

How old is this child? "Three months." What is the trouble? "Its bowels move eight or ten times a day." Only a little at a time? "Yes, only a little bit." Are you sure its bowels move as often as that? "Yes, I think they do."

I show you here, in this napkin, a collection of these bits of fæces which the child is passing continually, the mother says as often as eight or ten times a day, but it is not probable that it is so frequent. You see that the color of the fæces is about normal, but that they are deficient in moisture. They are dry and somewhat friable. If I break open a piece I shall find it a little white inside. No, it is very little changed in color from the outside, only a little whitish within.

The passages of young babies are never normally like this. They are of about the same color, but semi-solid. There is evidently here a lack of moisture, which may possibly arise from an insufficient secretion on the part of the intestinal glands. It may, however, arise from other causes. It was, I think, in 1869 that I alluded, in my writings (*Journal of Obstetrics*, Aug., 1869) to a peculiar anatomical condition occasionally existing in the bowels of new-born or young infants. It had been recognized before, by a few anatomists, that the intestinal tract is different in the young from what it is in the old. The colon is very much larger and longer, in proportion, in the child, than in the adult, and this peculiar condition often remains up to the age of five or six years. The child may have two or even three sigmoid flexures, or the real sigmoid flexure may not be found on the left side, but on the right. It has occurred that the colon has been on the right side and not on the left, in those cases of imperforate anus where the operation has failed to discover the sigmoid flexure on the left side. In the passages of the young, where the peristaltic action of the bowel is normal and the colon of the usual proportion, the passages will not dry out, but where the flexure is long, or there are two or three of them, the fæces will dry out, as in the case before you.

In the fœtus and new born the secretions of the intestines are very copious. There is a great deal of mucus and epithelium, which may become very dry and compressed, to such an amount,

indeed, as to constitute actual obstruction. I remember one such case in my own practice, where constipation existed, accompanied by vomiting and other symptoms of complete obstruction. Water was injected in large quantities; air was blown into the intestine, and carbonic acid gas also, by means of an apparatus prepared for the purpose, but all to no avail. At last symptoms of regurgitation took place, peritonitis set in, and the child died. I made a post-mortem examination and found that the condition was like this which I have mentioned. There were three sigmoid flexures, and in one of them an accumulation of epithelium, mucus and fæces had taken place, which was so hard that my probe passed through the mass with difficulty. Not long after I was called to a similar case and treated it in the same way, but without avail. I saw the case in consultation, and not liking to be caught in the same scrape again, was prepared to operate, when late one night my door bell rang and the physician in charge of the case came in and said, "Doctor, the child has had a passage." The child had passed a mass of mucus and epithelium, and finally got well. There have occurred to me a number of cases like this in children, that cannot be explained in any other way than by the fact that there were two or three sigmoid flexures, one on top of the other, and impeding the free passage of the fæces.

When you are called to such a case, where you suspect such a state of things, you are to regulate the diet so that there may be an abundance of water in the food. In fact, it is always better to have too much water in an infant's food than too little. In the choice of food, do not give tapioca, rice, potatoes, or even barley, which is my favorite child's food, but give oatmeal, in preference.

Purgatives ought not to be given except in very urgent cases; they will not act without great pain. You cannot do without injections, and from these you will derive great benefit. You may be compelled to use them for months and years. Remember that the constipation is anatomical, and hence may not disappear until the cause has disappeared, and this peculiar condition may exist even up to the fifth year. You may give an enema every day, not of soap and water or salt and water, but simply wash out the intestine with pure warm water, and wait until nature restores to the intestinal canal its proper proportion. Not until then will the trouble disappear, for it is based on anatomical peculiarities. Oftentimes the accumulation of fæces in these flexures will give rise to dullness on percussion on that side. It is so in this case.

In a number of cases the constipation was so obstinate that I had to scoop out the rectum repeatedly. Have patience, inject day after day, and you will succeed when the time comes for a condition of the colon descendens, such as is met with in more advanced age.

Another cause of constipation like this may be that there is an insufficient physiological action of the muscular layer of the intestine. This may occur where it is not sufficiently developed, as in feeble children. In another class of children this constipation does not appear until from six months to one year after birth, and then from being perfectly regular they become obstinately constipated. In this class of children the muscles of voluntary motion, as well as of the intestine, become diminished in power; they are rachitic children. The symptoms of rachitis need not be developed at first in the bones. Rachitis is not always a disease of the bones primarily. It is a disease of the general system, and there are a number of children in whom the first symptoms of rachitis is that of obstinate constipation; the worst cases are often those which commence with obstinate constipation. In these cases, where they occur as early as the second or third month, you will often find softening of the bones of the cranium, and the peculiar diaphragmatic groove. The child is often fat and vigorous looking up to the age of two or three months. Then, if obstinate constipation sets in, it is pretty safe to look for rachitis, and these cases are often, as I have before mentioned, the worst cases of rachitis, ending in effusion within the cranium, hydrocephalic symptoms, and sometimes death. You will not find these forms of constipation mentioned in the books, and should opportunity permit, I shall be glad to take the subject up again.

Medical Societies.

UNION MEETING OF THE LANCASTER CITY AND COUNTY MEDICAL SOCIETY WITH THE SOCIETIES OF ADJACENT COUNTIES.

Held at Columbia, Pa., April 7th, 1880.

Reported for the Medical and Surgical Reporter,

BY W. STUMP FORWOOD, M.D.,

Of Darlington, Md. A Visitor.

Physicians, as a class, have at command fewer opportunities for relaxation from business, and for general mental and physical recreation, than any other class of men; excepting, of course, those whose daily manual labors are essential to the actual support of their families. No clerk or assistant can fill their places in absence, as in other kinds of business. The work of the medical practitioner, though not always continuous, is never ending; and the intervals from actual professional occupation which might be termed leisure, are so uncertain as to interruptions, that they can but rarely be utilized for purposes of rest and pleasure, for the fear that the anticipated indulgence will all be dissipated in a moment by the hasty arrival of an urgent "call."

It is true that more social enjoyment might be indulged in, without detriment to patient or physician, if the latter was properly inspired with the sense of good to be derived from personal contact with the great men of the profession, and also possessed of the necessary energy and industry which will always enable him to devote all proper attention to his patients and at the same time allow him opportunities of cultivating his mind in a way to become a better physician, by attending meetings of medical men, which are designed for mutual instruction in the great science of medicine.

Union Medical Meetings, that is, meetings of the medical societies of adjoining counties, have recently been instituted, and have been productive of much good, by bringing together, under most agreeable circumstances, neighboring practitioners who would otherwise rarely meet. Thus, our domain of professional friendships becomes enlarged; and in like proportion, if we improve the opportunities, must our professional knowledge grow.

In keeping with the general spirit of the age in which we live, which is that of advancement and improvement, the Medical Society of Lancaster County and City, Pennsylvania, held a union meeting at Columbia, on April 7th, 1880. To this meeting were invited the members of the Societies of several of the adjoining counties in Pennsylvania, and also the members of the Societies from Cecil and from Harford counties, in Maryland; so that two States, as well as several counties, should be represented at the meeting.

As a special act of courtesy and respectful consideration, the host, the inviting Society, Lancaster, placed the entire programme for the conduct of the meeting in the hands of their invited guests; that is, all of the papers read before the meeting at Columbia were prepared by the visiting friends from other counties. All discussions suggested by the papers were, however, general, all present being desired to participate in them.

The arrangements for the meeting were intrusted to the able executive care of the following named gentlemen, as the General Committee, all of whom were residents of Columbia, or near by: Dr. J. A. Thompson, Dr. D. I. Bruner, Dr. J. F. Cottrell, Dr. T. M. Livingston, Dr. J. H. Lineaweaver, Dr. G. W. Berntheizel, Dr. S. Atlee Bockius, and Dr. Alexander Craig.

This Committee corresponded with various gentlemen in the different counties, that were to be invited, some weeks before the date fixed upon for the meeting, with a view to securing essayists for the occasion, and having their names and subjects announced on the printed programme that was to be sent out with the letter of invitation to the meeting.

The following is the Order of Exercises that was arranged in advance of the meeting; and to the credit of the essayists named be it said, and to the sagacity of the Committee in selecting them, every one of the twelve named appeared at the meeting, and performed his part of the programme. And the general sentiment of the meeting, very freely expressed, was that each one filled his part faithfully and satisfactorily, and contributed much to the entertainment and instruction of all.

The programme, which was quite diversified, as will be seen at a glance, and correspondingly interesting in the treatment of the subjects, was arranged as follows: —

1. Address of Welcome; by Dr. I. Bruner, of Columbia.
2. The Construction and Advantages of a New Mechanical Appliance for the Treatment of Disease of the Spine; by Dr. H. L. Coover, of Harrisburg, Pa.
3. Notes on Vital Conservation; by Dr. A. A. Hanna, of Port Deposit, Md.
4. Traumatic Perforation of the Intestine; by Dr. E. W. Meisenhelder, of York, Pa.
5. The Establishment of a State Board of Health as a Department of State Government; by Dr. J. W. Houston, of Collamer, Chester Co., Pa.
6. Rest, and its Relation to Disease; by Dr. S. B. Keiffer, of Carlisle. Pa.
7. Treatment of the Sick Stomach of Pregnancy; by Dr. W. S. Forwood, of Darlington, Md.
8. Duodenitis; by Dr. Jacob Hay, of York, Pa.
9. A Day at Gheel; or, the Cottage Treatment of the Insane; by Dr. J. Z. Gerhard, of Harrisburg, Pa.
10. Report of two Cases of Litholapaxy, with Remarks; by Dr. H. L. Orth, of Harrisburg Pa.
11. Embolism; by Dr. J. W. Kerr, of York, Pa.
12. A Report of a Post-mortem Examination of a Patient Dying of Cancer of the Omentum; by Dr. W. W. Dale, of Carlisle, Pa.

The meeting was convened at the Opera House, of which building Columbia may well be proud, on Wednesday, April 7th, 1880, at eleven o'clock A.M.

In the absence of the President of the Lancaster County Medical Society, Dr. J. A. Thompson, who was confined at his home by sickness, the chair was occupied by the First Vice-President, Dr. A. M. Miller.

Upon motion, Dr. P. J. Roebuck, of Litiz, was elected temporary Secretary.

The President then introduced to the meeting Dr. D. I. Bruner, of Columbia, who delivered the following address of welcome :—

"MR. PRESIDENT AND GENTLEMEN—This stated meeting of the Lancaster City and County Medical Society has been convened in this hall for the special purpose of receiving and communing with our friends of other medical societies. The physicians of Columbia and neighborhood have honored me with the pleasant duty of extending to you, gentlemen of the home and visiting societies, a cordial greeting.

"Those whom I represent would naturally desire that their kindly feeling should be expressed worthily, warmly, eloquently. In selecting me as their spokesman, however, they put aside all thought of rhetorical display. My title to this foremost place is seniority; not that I am so gray as our venerable president, whose absence, on account of sickness, I deeply regret; nor do I wear so many years as the honored father of our society; I am simply the senior physician of this place. But this seniority qualifies me, knowing so well by long association the feelings and sentiments of my townsmen of half a century of practice—nearly thirty years having been spent in Columbia—this qualifies me to express in their behalf, as I now most earnestly do, a sincere and hearty welcome on the part of my medical brethren especially. I welcome you, not only to our town, but to the highest places in our meetings.

"This assembling together of the physicians of neighboring counties is a recent custom—innovation rather, it has scarcely crystallized into a custom—but one which, I think, meets the hearty approval of every one of us, having at heart the interest and progress of our profession. With medical literature multiplied as it is beyond a

busy man's capacity to read, to say nothing of digest, some short road to knowlege becomes indispensable. The personal interchange of thought, of opinion and of experience, is a condensation, a combination, of our separate study, and research, and experiment. We meet to compare notes, expose critical cases, discuss the thousand questions arising in our ever-expanding and improving profession.

"New diseases, old diseases under new forms, new remedies, new combinations, new chemicals, all these demand our consideration, and many our condemnation. Our aim is to contribute each his quota to mutual improvement, to the elucidation of abstruse problems, the unraveling of seeming mysteries of disease. By contact we seek to burnish our minds, to sharpen our apprehensions, and to gather from the resulting discussion facts and data which shall stand us instead of personal experience. Our County, State and National Societies are fields for this same contact and consultation; but are not these reunions, free from the trammels of fixed time and place, of constitution and by-laws and routine, more gratifying and enjoyable?

"As a class, we physicians are separate and distinct from other men. Our thoughts, feelings, I may almost say our customs, are peculiar. We naturally seek congenial society; we find it within our own ranks. Aside from a strictly professional bearing, the influence of these assemblies in a social aspect is strengthening to our brotherhood.

"We must unite ourselves by every possible tie; for no distinct body, social, political or professional, can expect to exist without envy, detraction and opposition. We must stand firmly together against the traitors, the impostors, the humbugs, who intrude upon our ranks and strive for our name and place. We must denounce the ten thousand nostrums which flood the country with quackery in all its forms. By our efforts to prevent disease, to soothe, to strengthen, to heal suffering humanity, we must make good our claim to be indeed the conservators of health, the true and only ministers of healing.

"Gentlemen, we have not forgotten the kind reception, the cordial welcome and hospitable entertainment extended to and received by us at Port Deposit and Wild Cat. The members of Harford, Cecil, Oxford, York and Harrisburg Societies have endeared themselves to us by their kindness and congeniality. We, in turn, are the hosts, and will endeavor to make the occasion one of pleasure to our guests. This place has been selected for our assembly, because easy of access by rail from every direction; and the unequaled scenery through which our visitors have approached must have attuned their minds to high thoughts; we await their utterance. We keep in mind the lucid and erudite essays of past meetings, and look to you, gentlemen, for the papers of to-day. Let us, however, not forget that discussion is earnestly desired, and should be participated in by all who may feel interested in the subjects presented.

"Gentlemen, once more I welcome you warmly. I trust that this meeting will strengthen the bonds of fellowship, and help to elevate the standard of the profession.

"In conclusion, allow me to say—If your visit should prove as agreeable to you as it is flattering to us, you will carry with you only pleasing recollections of an occasion which we shall remember with gratification."

Physicians, as a rule, are not orators, nor even fair public speakers. Their walks in life are in the paths of quietness, if not of peace; in the chambers of the sick and the dying, where low-voiced whisperings alone are needed, or are advisable. Therefore, the great majority of physicians, when appearing before a public assemblage for the purpose of making some "remarks," even upon familiar medical subjects, feel themselves much embarrassed in their new and unpracticed rôle, for the want of that ease and freedom in delivery which can only be obtained or acquired by frequent practice.

In the delivery of this address of welcome, Dr. Bruner, although not making any effort at oratorical display, spoke clearly, distinctly, and in a most pleasant and feeling tone, which effected more in causing every hearer to know and to feel that he was welcome than could have possibly resulted from the most finished oratory where the inspiration of friendship and unity was wanting. Dr. Bruner spoke without notes, and his discourse and its delivery came well up to our estimation of a medical speaker—of what a medical man should say under the circumstances—and the happy and dignified manner in which he gave expression to the hearty welcome.

Although the programme, as before stated, was fully carried out, yet the papers were not all read in the order announced, for the reason that some of the essayists were delayed in their arrival in Columbia until after 12 o'clock.

The first paper read was by Dr. A. A. Hanna, of Port Deposit, Md., the subject being: "Notes on Vital Conservation." This was a good exposition of the views established by recent physiological researches, especially through the use of the microscope. The paper was well read, and appeared to excite considerable interest in the minds of the auditors.

The second paper, entitled, "The Establishment of a State Board of Health as a Department of State Government," was read by Dr. J. W. Houston, of Chester county. This was an exceedingly able and forcible presentation of an important subject. As an exception to the common experience in our profession with reference to public speaking, as I have previously remarked, Dr. Houston manifested decided ability in this accomplishment, and delivered his remarks upon the necessity for the establishment of a State Board of Health effectively and eloquently.

At the conclusion, his views were much commended by Dr. John Atlee, Sen., and others. The great difficulty in the establishment of such a board, and, consequently, the execution of the humane designs comprehended in the results of the duties of a Board of Health, lies in the obtuseness or the want of interest on the part of the State legislators. Dr. Atlee spoke with great earnestness and with much regret, upon the apparent difficulties which were placed in the way of the medical profession when desiring to engage

the attention of our legislators upon medical subjects, subjects purely philanthropical, and designed solely for the public weal. The Doctor appealed to the Secretary of the Society, Dr. Roebuck, who had been a State Senator, to explain why it was that the petitions of medical men before the Legislature received so little attention, such constant neglect and rejection; and wished to know, from his experience, by what method it was best to approach the Legislature with any hope of success for getting the necessary act passed for the establishment of a State Board of Health? The query, we regret to say, was not replied to.

The following resolution was offered by Dr. Houston, and was unanimously adopted:

Resolved, That the members of this Convention will use their influence in the several county Medical Societies herein represented, to instruct their respective delegates to the State Convention to therein advocate the necessity of again appealing to the General Assembly of this Commonwealth, for legislation establishing a State Board of Health as a department of our State Government.

The next paper read was one by Dr. S. B. Keiffer, of Carlisle, entitled "Rest, and its Relation to Disease."

This was an admirable paper, and was well impressed upon the attention of the audience; and a paper which might profitably be brought to the notice of the general public as well as to that of our profession.

Dr. Jacob Hay, of York, read the fourth paper to the Society, upon the subject of "Duodenitis."

Unfortunately, at the time of the reading of this paper we were occupied in the deliberations of one of the Committees, and did not hear any part of it.

Dr. J. Z. Gerhard, of Harrisburg, next came before the audience with an exceedingly interesting essay, detailing his experience and observations derived from "A Day at Gheel; or, the Cottage Treatment of the Insane."

Although we did not hear the whole of this paper, for the reason just assigned in referring to the paper of Dr. Hay, yet we heard sufficient to awaken an earnest desire to become acquainted with the remainder. Dr. Gerhard has been Senior Assistant Physician at the State Lunatic Hospital, at Harrisburg, for the past ten years. His paper was replete with interest; and it appeared quite evident that he had most industriously employed his "Day at Gheel" to the best advantage. His remarks were well read, and well received by his auditors.

The Doctor's visit was made in July, 1877. Gheel is an ancient town in Belgium, and is located about twenty-seven miles from Antwerp, in a southeasterly direction, and has been noted as a place for the treatment of the insane since the seventh century, through a period of eleven hundred years. An establishment of such unprecedented antiquity must of necessity possess a remarkable history. The insane at Gheel are not confined to a single hospital, or even to the town, but are scattered over a district measuring about thirty miles in circumference, and amidst a population of about 12,300. At the time of the Doctor's visit the insane numbered 1300. "The majority of the cases," the Doctor remarked, "belong to the chronic and demented classes, and live in the houses of the peasants, and some of them engage in the various domestic and field duties of the country." The town of Gheel, our essayist informs us, is the nucleus and governing centre of the community. The Doctor further states that "In 1858 an infirmary was erected at Gheel, and was placed under the supervision of Dr. Bulkens, who continued the physician in chief of the community until the time of his death, which occurred several years since. He was succeeded by his assistant, Dr. Peters. The Infirmary has accommodations for sixty patients, is occupied by the most recent and violent cases, and is arranged and managed on the plan of an ordinary hospital for the insane. The patients living in the cottages receive but very little medical treatment."

The original hospital for the insane established at Gheel partook more of a religious than of a medical character. The community was, and is, entirely under the jurisdiction of the Catholic Church; and the hospital was especially the offspring of the patron saint, St. Dymphne, an interesting religio-medical history of whom was given in the Doctor's paper.

"The great objection to Gheel," adds the author, in a private letter to the present writer, "is the defective medical supervision of the community."

We can scarcely feel surprised at this defective medical supervision when we reflect that the institution had its origin in prayer, rather than in medical skill.

At the date of the establishment of this ancient asylum for the insane, eleven hundred years ago, it was the prevailing opinion among men, except a few of the more learned, that mental derangements were purely the results of the action of the evil spirits, and that they could be exorcised in no way except by prayer. Hence the care of these unhappy patients usually fell to the lot of the Church, for its relief for their maladies. Among the ignorant much of this ancient superstition still prevails with reference to the treatment of mental diseases.

In the long history of St. Dymphne many miraculous cures are alleged to have been effected in return for the prayers of the devout and faithful.

Dr. Gerhard's entire paper, with additions, may be published at a future day.

The next speaker who appeared upon the stage was Dr. W. Stump Forwood, of Darlington, Md. The subject of his paper was, "The Treatment of the Sick Stomach of Pregnancy."

Our readers will excuse us from making any remarks upon this paper. With the permission of our good friend, the editor of the Medical and Surgical Reporter, each of our readers will have the privilege of reading the entire paper in the pages of this number of the journal (see page 23), when they can judge for themselves, after a careful trial, as to the merits of the treatment proposed for that direful malady.

At the conclusion of the reading of this paper some remarks were made by Drs. Atlee, Welchaus and M. L. Herr, as to the utility of other

methods of treatment, viz., ingluvin, pepsin, etc., which each had used with varying success.

The next paper in order was the report of a case of "Embolism," with illustrations, read by Dr. J. W. Kerr, of York. The case terminated fatally, and a post-mortem examination was made, which verified the diagnosis, and showed that the chief artery in both legs was completely occluded with clotted blood, from the feet to a point near the knees. The patient suffered horrible pain, and his legs, so far as the embolism extended, became perfectly black.

Drs. Atlee and J. Ziegler made a few remarks upon this interesting paper.

Dr. H. L. Orth, of Harrisburg, read the next paper, which was entitled "Litholapaxy." This paper was in illustration of old and of new methods of crushing stone in the bladder, and was accompanied with the different instruments which the Doctor relies upon as the best for accomplishing the object. The instruments appeared to be well adapted to the purpose, and competent for the exercise of powerful leverage.

Dr. Orth is a young physician, but is rapidly rising into the highest ranks of scientific medicine and surgery. We learn that he has successfully practiced ovariotomy under circumstances but little less than desperate.

The succeeding paper was read by Dr. W. W. Dale, of Carlisle, the subject being, "A Report of a Post-mortem Examination of a Patient Dying of Cancer of the Omentum." We may obtain some information from every carefully conducted post-mortem examination made, regardless of the special character of the fatal malady. This case of Dr. Dale's possessed several points of general interest.

In the Quarterly *Transactions* of the Lancaster County Medical Society, April, 1880, which number purports to contain only the Proceedings of the meeting at Columbia, April 7th, we find a paper on "Diphtheria," by Dr. J. L. Ziegler, of Mt. Joy. We did not hear this paper, nor hear of it; neither was it on the printed programme. The inference is that it was not delivered at the said meeting. In looking over the printed copy, we find that Dr. Ziegler relies chiefly upon mercury in the treatment of diphtheria. He prefers the cyanide of mercury, in minute doses. We will only remark in this connection our opinion, that, had the Doctor gone through such a malignant epidemic of diphtheria as the one we encountered about sixteen years ago—two or three lying dead in the house and awaiting burial at the same time—he would have acknowledged the utter futility of small or of large doses of mercury, or of any other treatment except the most heroic stimulation and antiseptic treatment.

At the conclusion of Dr. Dale's remarks, an excellent and highly practical paper was read by Dr. H. L. Coover, of Harrisburg, on "The Construction and Advantages of a New Mechanical Appliance for the Treatment of Disease of the Spine." Dr. Coover exhibited his appliances to the Society, and explained their application. One great advantage possessed by these appliances lies in their comparative cheapness as regards expense and their facilities for easy application.

The concluding paper was read by Dr. J. W. Meisenhelder, of York, his subject being the history of a case of "Traumatic Perforation of the Intestine." This was the case of a man of sixty-five years of age, who, upon attempting to get up into a large wagon, stepped upon the wheel, when his foot suddenly slipping off the wheel, his entire weight fell upon a corner of the wagon-body, and the whole force of the fall was expended upon a point in the abdomen. The patient immediately complained of agonizing pain in the part injured; and the pain continued without intermission up to the hour of the patient's death, which occurred thirty-three hours after the accident.

The Doctor terms this case one of perforation, which we, with due deference, must, in the interest of clear definitions, object to. By perforation we understand a wound produced by a sharp-pointed or by a boring instrument. The lesion, in the case referred to, was clearly and incontrovertibly a rupture.

Upon post-mortem examination of the case the rupture in the bowel proved to be only about the size of a split pea. It is astonishing how much suffering, and how speedily death follows in the midst of life and health, from such an apparently insignificant injury. We give in full the Doctor's concluding remarks upon this case:—

"The case is submitted to your consideration as one of the rare ones of medical literature. It is such a case as one sees but once in a lifetime. It illustrates with what extreme rapidity peritoneal inflammation manifests itself; and that its march is as destructive and blighting as a prairie fire. The promptness with which any injury to the peritoneum, either parietal or visceral, exhibits itself by unmistakable signs, is no doubt due to the fact that all the hollow viscera are well supplied from the solar plexus, aptly called the abdominal brain, with branches of that great sympathetic system which presides over those processes of economy not under the control of the will. From this great centre ramify minute filaments in every direction, and to every portion of the intestinal tract, and notice of injury at any point is rapidly flashed along these countless wires back to the centre, whence is returned, sharp and quick, the warning, which is the first step in Nature's effort to combat the destructive agencies which are striking with fiery tongues at human life. For he who has to do with either a frank, acute peritonitis, or with its more insidious chronic type, is standing on the ragged edge of a precipice which threatens to engulf and destroy."

The Vice-President, Dr. Miller, conducted the duties of the chair with dignity and dispatch, and all of the proceedings were harmonious and parliamentary.

A resolution was adopted, tendering the sympathies of the Association to the absent President, Dr. Thompson, in his sickness.

A bountiful dinner was provided for the delegates, at the Franklin House, a leading hotel in Columbia, at the expense, we believe, of the Committee of Arrangements. Certainly the visiting brethren were not allowed to pay for the same. And after the adjournment of the Society in the afternoon, between four and five o'clock, the good ladies in the families of the physicians

of Columbia had prepared a splendid lunch in the basement of the Opera House, for those who had long distances to travel to their homes. This consisted of delightful coffee, nice buttered rolls, cold meats, etc., all of which appeared to be enjoyed with the greatest relish, much heightened by the knowledge of the sources from which it came, and of the fair hands by which it was prepared, and the kindly feelings by which it was prompted. The ladies were in waiting themselves, and personally handed the refreshments, much to the pleasure, repeatedly and most freely expressed, of the visiting gentlemen.

Columbia, though not large, is a good-sized and beautiful town, and is rapidly growing. It is now a great railroad centre, the whistle of the locomotive being heard almost every hour of day and night. The roads here diverge to the four cardinal points of the compass.

After having finished their hasty lunch the crowd congregated at the depot, portions of them to go in every direction. Having now but a few minutes for pleasant chat and hurried farewells, the down train on the great "Pennsylvania" came rushing along, halted but a minute or two, and took off a large body of our friends to Lancaster city. We had scarcely time to renew our jokes or speak of parting, when another train came in and took off another large delegation to York; and about fifteen minutes later our Harrisburg friends took their departure; and, fourthly and lastly, and with a rather longer interval, we from down the river took our train for Port Deposit. Thus, within about one hour, between six and seven o'clock, the large number of strange physicians whose presence had excited and enlivened Columbia throughout the day had all departed to their several distant homes, and left Columbia, like "Tara's halls," deserted. They carried with them, however, the kindliest feelings for the welcome and the hospitality they had met with and enjoyed at the hands of the Columbia physicians, and especially from their wives. They departed feeling that the day had been well and profitably spent, that they had formed many new friendships with the good and the great men of the profession, which they feel will afford them enjoyment and instruction in the years to come. We know that all will excuse us for personal allusion when we say that no medical man can come in contact with such a man as the senior Dr. John L. Atlee without feeling that he has secured some pearls of wisdom that have fallen from his lips, and have stimulated in his bosom a more noble pride in his profession. This Nestor of our profession, who yet carries his years lightly, and with the springing step of active life, has recently celebrated his eightieth birthday. He informed us that he had no rest, but was as busy with his large practice as at any time for years past.

In conclusion, it is proper that we should express our warm feelings for the pleasure and instruction afforded us by our professional brethren of Lancaster county, and especially by those of the town of Columbia, for the kind welcome and generous entertainment extended to us in this delightful union meeting. This meeting, we trust, is a forerunner of many to follow, in which the physicians of neighboring counties, previously strangers to each other, and who have secluded themselves, as it were, from that contact with the profession the friction of which alone produces brightness, will be brought together more frequently, and upon more intimate and kindly terms. With such results to look forward to from this bright example, our Lancaster County friends may well congratulate themselves upon having inaugurated a means for social enjoyment and for professional instruction, alike honorable and commendable; and this example will doubtless have the effect of inducing other societies and contending physicians, who heretofore have

"Stood aloof, like cliffs asunder,"

to unite in kind, personal feeling, and in the great common cause of relieving the ills that flesh is heir to!

Editorial Department.

Periscope.

Scleritis and Sclero-Keratitis.

In an article on the treatment of inflammation of the sclerotic, which appeared in *Recueil d'Ophthalmologie*, May, 1880, Dr. Galezowski insists on the importance of clearly distinguishing between scleritis confined to portions of the sclerotic distant from the corneal limbus, and scleritis occupying the limbus. In the former case, the disease, though obstinate, is, as a rule, curable, and will leave no external traces upon the eye, nor permanently interfere with vision. The second variety, on the contrary, is frequently followed by grave complications in the cornea and iris, and may lead to permanent blindness. Both forms are intimately connected with a rheumatic or gouty diathesis, but may also be dependent on the presence of struma. As regards treatment in the first-mentioned variety of the affection, Dr. Galezowski has developed a certain procedure, which has given him excellent results. He first of all has recourse to alternate instillations of atropine and eserine, using the former twice a week, the latter every day. He then applies flying blisters to the forehead and temples, and uses ocular douches of steam. Internally, salicylate of soda is administered, in daily doses of from two to four grams, with hypodermic injections of pilocarpine. In scleritis of syphilitic origin he places his chief reliance on iodide of potassium. Each of these stages of treatment is illustrated by reported cases. In

certain instances the author has found great benefit from scarifications, at long intervals, of the inflamed and swollen surface of the sclerotic. The incision should be perpendicular to the corneal border, and should extend down to the sclerotic. If done once every ten or twelve days a single incision will often suffice to arrest the further progress of the affection. The second variety of scleritis, viz., sclero-kerato iritis, is always localized at first in the ciliary region, very near to the corneal border, whence it spreads progressively to the cornea and the iris. In such cases the author considers there is only one really efficacious treatment, viz., iridectomy. In most cases the pain is at once relieved, and within ten or fifteen days after cicatrization has become established the swelling and redness disappear, and the affection is cured without danger of relapse. In support of this doctrine he gives the history of two cases. In one the affection had proved rebellious to all treatment, and the cornea was becoming gradually infiltrated throughout its whole extent. There was also very intense peri-orbital pain. Iridectomy gave immediate relief, and subsequently removed all the symptoms. In another, a strumous girl had suffered for several months from sclero-keratitis. Both eyes were affected; there were interstitial deposits in the cornea, posterior synechiæ, and symmetrical inflammation of both sclerotics. In this case, also, the results obtained by iridectomy were most satisfactory. The author concludes by stating that he considers the above operation to be the only successful plan of dealing with these troublesome cases.

The Diagnosis Between Syphilis and Laryngeal Phthisis.

M. Moure compares, in *Annales des Maladies de l' Oreille et du Larynx*, February, 1880, the symptoms of these affections at different periods: 1. The early stages of laryngeal phthisis with secondary syphilis. 2. The ulcerative stages of laryngeal phthisis with tertiary syphilis. The principal symptoms which he passes in review are those furnished by the voice, cough, expectoration, pain, respiration, enlargement of the glands, and local appearances of the disease. In the secondary period of syphilitic laryngitis the voice may be normal or hoarse; in the tertiary rarely aphonic, but always hoarse. In early tuberculosis the voice is husky, and there may sometimes be aphonia; in the ulcerative stage aphonia is always present. In secondary syphilis there is no cough; it is also rare in the tertiary stage, but is very frequent in the ulcerative period of laryngeal phthisis. There is no expectoration in secondary syphilis; but it is present, and may be blood-stained and purulent, in the tertiary. In commencing laryngeal phthisis it is mucoid, and in the ulcerative period muco-purulent. The pain is nocturnal in syphilis. The cervical and submaxillary glands usually swell in syphilis, whereas in tuberculosis they do not enlarge, but often atrophy. Both affections show hyperæmia of the mucous membrane; in phthisis it affects the arytenoid region, and is roseate in color; in syphilis it affects the front part or the free edge of the vocal cords, and in color is dark red. The mucous patches of syphilis project above the mucous membrane, are depressed at their centres, and are surrounded by inflammatory redness. Tuberculous erosions, though gray, like the mucous patches, differ, in not projecting above the level of the mucous membrane; their edges are confused and irregular. Gummata are apt to be mistaken for tubercles, and syphilitic for tuberculous ulceration. Gummata are large and yellow, and cause projections under the mucous membrane; tubercles are gray, opaline and small, and give a granular appearance to the mucous membrane. Gummata affect chiefly the epiglottis, the glottic portion of the larynx, and the trachea; tubercles appear most often on the subglottic portion of the arytenoid cartilages. The ulcers in syphilis are solitary or few in number, their edges are hardened and cut perpendicularly; in tuberculosis they are oval or round, with dentated edges, often covered with fleshy granulations or polypoid vegetations. Both ulcerations affect the epiglottis, but differ in their mode of evolution. In phthisis they proceed from below upward, and from the periphery to the centre; in syphilis the process is reversed. The affection can always be arrested in syphilis; this is impossible in tuberculosis, especially if the ulcerative stage has been reached.

The Action of Salicylate of Soda upon the Urea, and Uric and Phosphoric Acids of the Urine, in Acute Rheumatism.

This forms the subject of a paper by Dr. Lecorché and M. Talamon, in the *Revue Mensuelle de Médecine et de Chirurgie*, for March.

The authors first briefly notice and sum up the results of the few researches recorded by previous observers as to the state of the urine after the administration of salicylate of soda. "*En résumé*," say they, "although differing as to details, all these (seven) authors, save one, agree that in a general way the salicylate of soda increases the proportion of solid matters in the urine. Some have found a diminution of urea, while others noted no appreciable modification of it. The uric acid was increased, according to the majority, diminished, according to others. One found the phosphates increased, another noticed no decided alteration of them."

They then record at length, as well as in tabular form, their own observations in ten cases of acute or subacute rheumatism treated by salicylate of soda, and the conclusions at which they arrive are thus stated:—

1. In the first period, during the administration of the medicine, it increases the density and color of the urine without augmenting the quantity; to this period succeeds a second (corresponding to the discontinuance of the medicine), characterized by a polyuria more or less abundant and more or less prolonged, with rapid lowering of the density and color below normal, and which is no other than the period of convalescence.

2. The urine remains in general acid; during the second period it is often neutral, and occasionally alkaline for a variable time.

3. The urea and uric acid undergo immediately, under the influence of the medicine, an

enormous increase. This increase takes place generally from the first twenty-four hours; it may, in some cases, be retarded for forty-eight or seventy-two hours. It lasts for three or four days. To this elevation succeeds a progressive lowering, sometimes abrupt, which brings back the amount of urea and uric acid to the normal or lower. In subacute rheumatism, the rise in the urea and uric acid is less prolonged than in acute rheumatism, not exceeding the first twenty-four hours.

4. The proportion of phosphoric acid rises at the same time as that of the urea and uric acid. Like them its appearance may be retarded. The increase of the phosphoric acid continues longer, especially in acute rheumatism, than that of the urea and uric acid; but the persistence of the increase after the initial elevation ought not to be attributed to the salicylate; it is, like the polyuria, the natural and ordinary consequence of the convalescence.

Phosphate of Bismuth.

M. Tedenat recommends, in *Montpellier Médical* the employment of phosphate of bismuth in preference to the subnitrate. The anti-diarrhœal action of phosphate of bismuth is manifested in the same way as the subnitrate. In consequence, however, of its greater insolubility, the phosphate acts in rather weaker doses, especially in gastric affections. Notwithstanding the acidity of the gastric fluids, it is not in the slightest degree affected, which is but natural, since it resists strong acids, even in a concentrated form. The phosphate acts in somewhat smaller doses than the subnitrate, and the difference in activity is sufficiently great to create a superiority, from this point of view, in favor of the phosphate. The doses are likewise varied, according to the nature of the case. They are usually about from one to two grams. The mode of administration is absolutely identical with that of the subnitrate. With infants it suffices to place the desired quantity on the tongue, and to offer the breast or bottle. The salt is easily conveyed into the stomach, and it is possible by this means to administer large doses. Adults take this drug suspended in some liquid. In many cases some advantage is found in making it into sweetmeats and pastilles of about one or two grams. They become disintegrated in the mouth, and the phosphate is gradually conveyed into the stomach without the patient having been able to perceive the presence of an insoluble salt in the mouth.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——*Godey's Lady's Book* for July contains, as usual, besides the latest fashions, a large amount of interesting reading matter, both poetry and prose.

——We acknowledge the receipt of the "Fifty-sixth Annual Announcement of the Jefferson Medical College," of Philadelphia. The Session of 1880–81 will begin on Monday, October the 4th.

——"Bromide of Ethyl—its Toxicological Action," and "A New Narcotic, Piscidia Erythrina—Jamaica Dogwood—its Physiological and Toxicological Action," are the respective titles of two papers, by Isaac Ott, A.M., M.D., late lecturer on Experimental Physiology, University of Pennsylvania, which come to us in the form of reprints from the Detroit *Lancet*, June 1880.

——A lecture on "Coccygodynia," delivered in the Chicago Medical College, by Edward W. Jenks, M.D., Professor of Medical and Surgical Diseases of Women in said College, and a treatise on the "Treatment of Puerperal Septicæmia by Intra-uterine Injections," by the same author, come to us in the form of reprints, one from the *Medical Record*, April 17th, 1880, and the other from volume iv of Gynecological *Transactions*, 1880.

BOOK NOTICES.

The Philadelphia Medical Register and Directory, with a List of the Physicians in Pennsylvania, New Jersey and Delaware. Edited by William B. Atkinson, A.M., M.D., Permanent Secretary of the American Medical Association, and of the Medical Society of the State of Pennsylvania; late President of the Philadelphia County Medical Society, etc., etc. Philadelphia, Collins, printer, 705 Jayne street, 1880. Cloth, small 8vo, pp. 438. Price $2.00.

The sixth edition of this useful little book is now ready, and the editor has again added largely to its contents, thus increasing the volume by about thirty pages, and rendering the work in every way more complete than any of the previous editions. It is a book which we believe no physician within this State should be without, containing, as it does, a short historical sketch of medical societies, whether national, state, county or city; of medical schools and kindred institutions, hospitals, dispensaries, homes, reformatories, benevolent associations, together with a list of instrument makers, dentists, nurses, etc., etc., and also a complete directory of physicians in Philadelphia, in Pennsylvania, in New Jersey, and in Delaware, giving the college from which they graduated, with date of graduation. This, we believe, constitutes an important improvement on former editions. It has been gotten up in a neat and elegant style, and will, we hope, have a large sale.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE MEDICAL ASPECTS OF EDUCATION.

II.—Household Education.

The fate of the individual is usually determined by the training he receives in the first twelve years of life. At that period the mind is developing its powers, and the body is successfully combating or else hopelessly yielding to hereditary taints. As the ante-natal education decides the character of the race, so does the training of the infant govern the after life of the individual. Then, if ever, must all resources of hygiene be summoned to make the best of the material now supplied by the ancestral lines. This period is usually passed at home, under parental and especially maternal care. Hence the enormous importance of parents instructing themselves in the hygiene and education of infants and children. How sadly these studies are neglected; how gross and unpardonable the ignorance of them, is only too clearly proved by the terrible mortality among children in nearly all classes and countries. Turn to what tables of death rates we may, in nearly all we find the annual deaths of children under thirteen to amount to from one-third to one-half the whole number. Undoubtedly many of these are preventable deaths; and when to this number are added the countless thousands who survive past that age to drag out lives darkened and impaired by early neglect, or not less injurious early indulgence and misdirected cares, the misery brought about by parental ignorance cannot be estimated.

It is eminently the duty of the physician to correct this condition of affairs. We consider that every medical man called in to attend children should at an early opportunity inquire whether the mother has qualified herself for the care of her offspring by a perusal of some brief, plain, practical treatise on the subject. If she has not, he should not rest satisfied until she has obtained and studied one.

No mother will seek to avoid this labor if its importance is explained to her. Thousands will be thankful their life long for the timely suggestion. There are several such books, and their dissemination cannot fail to redound to the national benefit.

It is needless here for us to go into any explanation of the details of instruction which it is desirable to give in this manner. The grand principles of domestic hygiene are well known to all our readers. They are embraced in two categories. The one considers the child's surroundings and his physical functions; the other his senses, emotions, intellect and will. Neither is secondary to the other. Both are absolutely requisite to complete the full idea of Education.

Under the first come the doctrines of exercise and repose, pure air and abundant light, bathing and clothing, food and drink, work and play, and the like. Under the second should be taught the well defined principles of training the observing and reflecting faculties, of self control and self denial, of obedience and reverence, of cheerfulness and industry, the government of the appetites and the respect for truth. All these are essential to education, and not less, but more so from a purely medical point of view. How many

constitutions are ruined, how many lives sacrificed, by a lack of training in any one of these particulars!

At this period, also, the inherited tendencies to disease can be most successfully combated. The taints of phthisis and scrofula, gout and syphilis, and the like dyscrasiæ, should be diligently sought for, and when discovered, the proper prophylactic treatment promptly instituted, and persistently carried out. In very many instances such tendencies can be wholly eradicated before the child grows into an adult, and is ready, by marriage, to perpetuate the race.

But such education must be begun *early*. It cannot be begun too early. The enormous influence of *habit* must be called into our aid. Habit in the parent becomes heredity in the offspring; in the child it becomes character in the adult. The impress on the plastic mind of youth hardens to an indelible mark on the tougher material of manhood. We cannot, therefore, be too attentive to the dissemination of sound information of the proper education of infancy.

Notes and Comments.

Therapeutical Notes.

FORMULA IN GONORRHŒA.

Dr. Herbert L. Snow publishes, in the *British Medical Journal*, April 17th, 1880, the following formula, which in his hands has proved of great service, and which is not particularly unpalatable:—

℞. Ol. copaibæ,		
Ol. cubebæ,	āā	ʒ ij
Liquor potassæ,		ʒ iiiss
Tinct. aurantii,		ʒ iij
Syrupi simplicis,		ʒ ij
Aq. menth. pip.,	q.s. ad	ʒ viij. M.

Sig.—Two tablespoonfuls, three times daily.

As an injection, he regards the liquor potassæ permanganatis (ʒ iij ad aquæ ʒ vj) as by far the best injection, and it has the great advantage of being serviceable all through the acute stage of gonorrhœa. It should be used very frequently; and subsequently, a little zinc sulphate may be added, with benefit.

LOCAL ANTISEPTIC TREATMENT OF SMALLPOX.

Dr. Ernst Schwimmer, of Bruda-Pesth, states, in *Deutsches Archiv für Klinische Medicin*, *that* he has obtained a considerable amount of success in the treatment of smallpox, by the use of a paste composed of—

℞.	Carbolic acid,	4 to 10 parts
	Olive oil,	40 parts
	Prepared chalk,	60 parts.

Under its use the drying of the pustules took place some days earlier than usual, and in several cases no great amount of suppuration occurred on the face.

Meat-Bread.

The *Medical Press and Circular*, June 2d, 1880, speaks of this invention, which is described by M. de Parville, in the *Journal des Debats*:—

Usually, when we eat we take the trouble of digesting at the same time our bread and our meat. Some one has conceived the idea of saving all this double work. M. Scheurer-Kestner has found the means of compelling the bread to previously digest the meat; that is so much gain for the stomach. And then, what a simplification: instead of concerning oneself with providing beefsteaks, chops, etc., there is nothing to do but provide the bread. The method is expeditious, and will be of importance to the soldier in campaign, the hunter and the traveler.

Certain juices digest meat, the juice of the papaya notably, the juice secreted by the so-called carnivorous plants, vegetable pepsin, etc. The fibrine is attacked and dissolved in the juice. M. Scheurer-Kestner, father of the senator of that name, has discovered the very remarkable fact that during bread baking there is produced a peculiar ferment which determines the complete digestion of meat. A beefsteak cut into small bits and mixed with flour and yeast disappeared entirely during baking. Its nutritive principles are dissolved and incorporated with the bread. The curious point is that the meat, which is itself putrescible, keeps indefinitely in this state. M. Scheurer-Kestner fils has placed before the Académie bread, still excellent, which was prepared in 1873. It was neither mouldy nor mitey. At first, M. Kestner employed raw meat. He mixed 500 grams of flour with 300 of fresh beef, chopped fine, adding water in proper proportion, and waiting till the dough began to ferment. After two or three hours the meat had disappeared, and the bread was baked in the usual way. The bread-meat thus obtained has a slightly disagreeable, sourish taste.

M. Scheurer-Kestner avoids this by previously boiling the meat for an hour with the quantity of water necessary to moisten the flour. The fat should be cut away from the meat, and but little salt added. Salt, being hygrometric, tends to

render the bread moist and prevent it keeping. A part of the beef is advantageously replaced by lard. The proportion of 50 meat to 100 flour must not be exceeded. Beyond that the digestion of the meat is incomplete. To tell the truth, adds M. de Parville, the meat-bread we tasted at the Académie, and which was prepared in the month of June last, looks very good, but it does not excite the appetite. Good, savory roast beef will undoubtedly be always more pleasing to the jaded stomach. However, exceptionally, and especially for preparing nutritive soups, it seems likely to serve a useful purpose. It is only necessary, having cut the bread in slices, to boil eighty grams of the biscuit in a litre of water for twenty minutes and salt to taste.

The meat-bread was sent to General Chanzy, in 1873, that he might try it for the troops. "The soup thus obtained," wrote M. Scheurer-Kestner, "although very *eatable*, is not sufficiently *appetizing*. The soldier, it is to be feared, would soon grow tired of it. However, further trial ought to be made." Since 1873 its manufacture has been greatly improved. The addition of lard gives taste to the bread. M. Scheurer-Kestner states also that veal incorporated with the bread furnishes excellent soup, which would be suitable for the sick and wounded.

Gunshot Wound of the Base of the Brain, Followed by Recovery.

Dr. Diez reports, in *El Siglo Medico*, a remarkable case of recovery after a gunshot wound, presumably of the base of the brain. The patient was aged nine years, and was accidentally wounded by a revolver bullet, nine millimètres (0.35 inch) in diameter. The projectile was discharged at the distance of a few feet only, and passed through the right temporal fossa at a point corresponding to the centre of the zygomatic arch, between the external angle of the orbit and the tragus of the ear, lodging at a corresponding point, but six millimètres higher, on the left side of the head. Among the symptoms noticed were partial loss of consciousness, recovered, however, within an hour, considerable epistaxis, exophthalmos, with complete loss of vision in the right and photophobia in the left eye. Slight cephalalgia, confined to the anterior portion of the head, was present; and a dull, buzzing sound, heard subjectively, followed the least movement. Hemiplegia was well marked on the right side of the body. The ball was extracted, and almost immediately the photophobia in the left eye disappeared. The treatment consisted in water dressing and rest; and recovery was rapid and complete. Suppuration commenced sixty hours after the injury; the exophthalmos disappeared on the seventh, and the hemiplegia on the third day. Recovery was complete on the twenty-fourth, sight having been perfectly restored, and no apparent ill effects remaining. The author asks what could have been the actual lesion in this case, and considers that the anterior lobes and optic nerve can hardly have escaped direct injury.

The Prognosis and Treatment of Primary Syphilis.

M. Mauriac, in *La France Médicale*, March 3d, 1880, and following numbers, considers at some length the prognosis and treatment of the primary manifestation of syphilis. The chancre is looked upon by Mauriac as the first sign of a general constitutional disease of indefinite duration. Unfortunately, we have not yet discovered any rules which permit us to foretell, with any certainty, from the character of primary chancre, what will be the number, nature, progress, duration, etc., of the later manifestations. The primary lesion, when extensively ulcerated or phagedenic, may, to a certain extent, lead us to expect a grave form of early outbreak of the constitutional disease; but it does not give us any exact information as regards the prognosis of the later periods, nor as to whether visceral lesions are likely to occur or not. With respect to the prevention of general syphilis by excision of the initial lesion, the experiments of Auspitz, Unna and Kölliker are referred to; and the author states that M. Paqvalin, of Abo, Finland, informed him that he had cut out infected chancres in eighteen cases, in one of which he had also removed the inguinal glands. The chancres were of one or two weeks' duration. In no case were general symptoms prevented. M. Paqvalin also had under observation two men who had had intercourse with the same syphilitic woman. One of the two men got the skin of the penis chafed during coitus. The excoriated spot was excised at the end of eight days. No syphilis appeared. The other man had an infecting chancre at the end of thirty days. M. Mauriac thinks that, although the practice of excision has not yet given proof of being of incontestable value, it should not, therefore, be neglected. However, that this abortive method may be placed above criticism, several conditions, rarely found in the same person, are necessary. First, one ought to be sure of the diagnosis. But, asks Mauriac, is this possible during the first few days

of the sore, and before adenopathy has appeared? And if the glandular enlargement were already present, would it not be too late to prevent general syphilis?

The Uncertain Action of Diuretics.

Dr. Maurel relates, in *Bulletin General de Thérapeutique*, March 30th, 1880, the results of a series of experiments which he has lately conducted with a view to study the action of certain of the most commonly used diuretics, such as potassic nitrate, chlorate, acetate, and iodide, sodic salicylate, digitalis, colchicum, and squills, the latter in the form both of tincture and of oxymel. The experiments extended over a period of forty-six days, and were undertaken on the same individuals. The general conclusions pointed to great uncertainty in the diuretic action of all these medicines; the most active was potassic nitrate, which increased the solid constituents as much as ten per cent. in the twenty-four hours. The other substances gave an increase of from five to six per cent. only. Digitalis alone gave constant results upon the excretion of water, which it notably augmented. The author believes that diuretics, as a class, whether administered in health or in disease, have very little real power. In many cases the increased excretion which they apparently induce should rather be set down to other causes, such as changes in temperature, nervous influences, or a 'crisis' in certain morbid states. The real proof of the power of diuretics would lie in their augmenting the urine at periods when it was naturally suppressed, such as in the early febrile stage of many affections; but, judged by this test, all his experiments point to their being practically inefficacious.

The Physiological and Therapeutic Properties of the Alkaloids of the Pomegranate.

According to the London *Medical Record*, June 15th, 1880, M. Dujardin-Beaumetz read a paper on this subject at the meeting of the Paris Académie de Médecine on May 18th, in which he postulated the following conclusions: 1. The alkaloids of the pomegranate possess real and powerful physiological properties. 2. These alkaloids induce paralysis of the motor nerves, while preserving intact muscular contractility. They do not attack sensibility, and seem to strike the motor nerves at once in their muscular terminations. They act like curare. 3. The sulphates of pelletierine and of isopelletierine possess very active tænicide properties, and in doses of three centigrams (1.2 grains) in a solution containing half a gram of tannin, they induce in the majority of cases (thirty-seven times out of thirty-nine, according to Dujardin-Beaumetz, and nineteen times out of nineteen, according to Laboulbène), the expulsion of the tænia, with the head. 4. New attempts should be made to apply the physiological properties of these salts in the treatment of certain diseases; in the first instance, in those in which curare has already been indicated, as tetanus and rabies; in ocular affections, in which it is necessary to induce active congestion; in the fundus of the eye; finally, in certain forms of vertigo, especially in that of Menière's disease.

The Local Use of Nascent Iodide of Mercury.

Dr. M. Charlouis, of Sumatra, reports, in *Vierteljahresschrift für Dermatologie und Syphilis*, No. 4, 1879, two cases of syphilitic serpiginous ulceration of the foot, treated after a somewhat novel method. After failure to produce improvement with large doses of iodide of potassium internally, and mercurial ointment locally, with occasional cauterizations with lunar caustic, the following treatment was adopted: The ulcers were penciled with tincture of iodine, and directly afterward covered with a layer of mercurial ointment. A sensation of heat in the part followed, lasting, however, only a short time. Within a week the ulcers healed in both cases. The author thinks the rapid and favorable result due to iodide of mercury forming at the point of application, and acting on the tissues in its nascent state.

Correspondence.

A Point of Difficulty not Alluded to in the Existence of Partial Laceration of the Female Perineum.

Ed. Med. and Surg. Reporter:—

Of late much has been written in regard to the importance of partial lacerations of the female perineum. Notable are the articles of Dr. Reamy, of Cincinnati; Dr. Garrigues and Dr. Thomas, of New York. All these articles are worthy of every man's patient study.

Says Dr. Thomas, in his article entitled "The Female Perineum, its Anatomy Physiology and Pathology," "If cases of decided laceration of the perineum be closely followed up, from the lying-in room to the end of life, and all the evils which immediately and remotely arise from this accident be intelligently noted, the list would be a long one; all not, of course, showing themselves in every case, but some occurring to one woman and some to another. They may be thus presented: Septicæmia, anterior and pos-

terior uterine displacement, prolapsus, cystocele, rectocele, chronic cystitis, chronic rectitis, uterine engorgement and hyperplasia, subinvolution of uterus and vagina, destruction of power of uterine ligaments, development of tendency to abortion, impairment of sexual gratification to the male, neuralgia affecting the site of the rupture. Presented thus, this array may appear unnecessarily formidable, but there is not one pathological condition mentioned which practical men will feel inclined to question the occurrence of as a consequence of puerperal laceration of the perineal body."

Certainly the list is long and formidable enough, but I desire to add one other important evil. It is this: an inability to empty the rectum. Constipation, with all its train of secondary evils, follows, and this form of constipation cannot be cured until the laceration of the perineum has been closed. Why should it occur to a woman who has suffered laceration of the perineum down to the sphincter ani muscle? Straining efforts with the abdominal walls and diaphragm are not, *per se*, disturbed. True enough, but when pressure is brought to bear by these agencies upon the rectum, the counter pressure necessary and exerted by the muscles which unite in and help make up the perineum is wanting. Thus the woman may strain until she forces her uterus to the vulva, and she fails to so squeeze the rectum as to be able to dislodge its contents.

Some months ago a lady came under my care suffering from some singular nervous phenomena. She was a resident of Philadelphia, aged thirty-seven; had borne two children, the youngest aged nine years; an examination revealed a laceration of the cervix uteri on the right side, and a laceration of the perineum back to the sphincter ani. Note a few of her symptoms; "*Constipation*, bearing down pain, backache, sleeps badly, changes irregularly, leucorrhœa, cardiac palpitation, tinnitus aurium, easily startled, when stooping air gushes from the vagina, sudden movements in bed followed by escape of air from the vagina, etc.

My advice was an operation for each of the lacerations, as a starting point. After some preparatory treatment I closed the cervix on February 12th, 1880, and the perineum on February 20th, 1880. Ether was given on both occasions, by Dr. Purviance. Good union followed each operation.

Two months passed before I saw the patient again, after two weeks from her last operation. When I saw her after two months I found her looking very much improved, and she said to me, "Doctor, my ears are not any better yet." "Well," I said, "I am sorry that is so, but am very glad that was not promised. But you are looking well. Now tell me in what particular you are benefited." "Well," she answered, "my back is better, I have no whites, I sleep better, I hav'nt any bearing down pains, and I change regularly once a month. Have you noted any other improvement? "Yes; my bowels are all right." What do you mean by that? "Well, *when I strain I can empty the bowel.*" This is the point; here a patient notes it accurately, remarks it voluntarily, and is cured, without drugs, of a persistent constipation.

I could cite other instances, but this is enough to elucidate the point I desire to call attention to. The contributions alluded to are recent and very valuable.

R. Stansbury Sutton, M.D.

Pittsburg, Pa.

News and Miscellany.

The International Hygienic Congress.

The Congress will be held in Turin early in August next. The conference will last a week, but the exact day of opening is not yet fixed. At the conference held in Paris, in 1878, it was decided to hold a congress in Turin in 1880, and the Società d'Igiene di Torino has undertaken its organization. Foreigners are especially invited to attend, and it is stated that, although French is generally regarded as the official language of international congresses, yet addresses may be given in any language, and they will be translated and published in French and Italian. The general scope of the Congress is to be the same as that held in Brussels in 1876, and in Paris in 1878, but all matters of detail are left for decision until the Congress actually meets. Professor Hyacinthe Pachiotti, Rue St. François de Paul 25, Turin, is ready to receive the names of those interested in the Congress, and to send information. As at present arranged, the sections will be as follows: 1. General and International Hygiene. 2. Domestic Hygiene. 3. Professional Hygiene. 4. Hygiene of Schools and of Children. 5. Hygiene applied to Agriculture. 6. Hygiene applied to Industries. 7. Veterinary Hygiene. 8. Naval and Military Hygiene. 9. Safety Appliances of all kinds. 10. Chemistry, Architecture, etc., applied to Hygiene. The University and other bodies have announced their intention of throwing open their suits of rooms, museums, libraries, etc.

Official List of Changes of Stations and Duties of Medical Officers of the Marine Hospital Service of the United States. April 1st, 1880, to June 30th, 1880.

Bailhache, P. H., Surgeon. Detailed as Chairman of the Board for the Physical Examination of Officers of the Revenue Marine Service. April 28th, 1880. Detailed as Chairman of the Board for Physical Examination of Candidates for Appointment as Cadets in the Revenue Marine Service. May 21st, 1880. Detailed as Medical officer, Revenue bark Chase, during practice cruise. June 1st, 1880.

Miller, T. W., Surgeon. Detailed as Chairman Board of Examiners, to convene in New York June 21st, 1880. June 4th, 1880.

Long, W. H., Surgeon. Granted leave of absence for ten days, from April 16th, 1880. April 14th, 1880. Detailed as member of Board to Select a Site for a Marine Hospital at Memphis, Tenn., May 12th, 1880.

Fessenden, C. S. D. Surgeon. Detailed as Member Board of Examiners, to convene in New York June 21st, 1880. June 4th, 1880. Granted

leave of absence for eight days, from June 13th, 1880. June 9th, 1880.

Sawtelle, H. W., Surgeon. Detailed as Recorder of Board to Select a Site for a Marine Hospital at Memphis, Tenn. May 12th, 1880.

Doering, E. J., Surgeon. Detailed as Recorder Board of Examiners, to convene in New York June 21st, 1880. June 4th, 1880.

Fisher, J. C., Passed Assistant Surgeon. Granted leave of absence for thirty days, from May 6th, 1880. April 21st, 1880. Detailed as Recorder of Board for the Physical Examination of Officers of the Revenue Marine Service. April 28th, 1880.

Godfrey, John, Assistant Surgeon. To report to Board of Examiners, for examination for promotion. June 4th, 1880.

Brown, F. H., Assistant Surgeon. To act as Inspector of Unserviceable Hospital Property at Boston, Mass. April 13th, 1880. To report to Board of Examiners for examination for promotion, June 4th, 1880.

Goldsborough, C. B., Assistant Surgeon. Detailed as Recorder of Board for the Physical Examination of Candidates for Appointment as Cadets in the Revenue Marine Service. May 21st, 1880.

Keyes, H. M., Assistant Surgeon. To act as Inspector of Unserviceable Hospital Property at St. Louis, Mo. April 13th, 1880.

Mead, F. W., Assistant Surgeon. To act as Inspector of Unserviceable Hospital Property at San Francisco, Cal. April 19th, 1880.

Porter, F. D., Assistant Surgeon. Granted leave of absence for fourteen days from July 2d, 1880. June 29th, 1880.

PROMOTION.

Fisher, J. C., Passed Assistant Surgeon. Promoted to be Passed Assistant Surgeon. April 2d, 1880.

OBITUARY NOTICES.

—Samuel Messenger Bradley, F.R.C.S., Surgeon to the Manchester Royal Infirmary, died on May 27th, at the early age of thirty-nine. He was a brilliant surgeon, a cultured gentleman, and one of the brightest and wittiest of companions. Mr. Bradley was born in 1841, and qualified for admission to the medical profession by becoming a Member of the Royal College of Surgeons in 1862; and in the same year Licentiate of the Apothecaries' Society. He passed the examination for the Fellowship of the College of Surgeons in 1869. After he had qualified, he entered the Manchester Royal Infirmary as assistant physician. For a time he acted as Professor of Physiology in Stonyhurst College, and was Surgeon to the Ancoats and Ardwick Dispensary. Mr. Bradley was Lecturer on Practical Surgery at the Medical School of the Owens College, having previously been Lecturer on Anatomy in that Institution.

He has also contributed largely to medical literature. His "Manual of Comparative Anatomy and Physiology" was first issued in 1869; and the second edition, issued at the close of 1873, was entirely rewritten. A third edition appeared in 1875. His latest book, "On the Injuries and Diseases of the Lymphatic System," was published last year, and met with warm approval. In conjunction with Mr. Walter Whitehead, he edited the Manchester *Medical and Surgical Reports* for 1870 and 1871, and remained as one of the editors for some time after the amalgamation of the publication with a similar serial at Liverpool, when it became the Liverpool and Manchester *Medical and Surgical Reports*. To this publication Mr. Bradley contributed several papers of professional interest, and one of more general scientific interest on the "Shape of English Skulls." Mr. Bradley's anatomical studies had led him to the cognate field of anthropology. A note by him on the peculiarities of the Australian crania was read at the meeting of the Anthropological Institute, on May 6th, 1872. His observations were based upon an examination of some skulls, brought by Mr. G. Roberts, Jr., from the borders of Lake Albert, which had belonged to members of a tribe who were "without superstition of any kind."

QUERIES AND REPLIES.

Dr. C. E. O., of Miss., requests information as to the opinion of the best surgeons in regard to hypodermic injections of carbolic acid in hemorrhoids, amount injected and number of injections necessary.

Ans.—We would refer him to the MEDICAL AND SURGICAL REPORTER for Jan. 7th, page 55; we have used it ourselves successfully, combined with ergotine in the following formulæ:—

℞.	Acid carbolic,	gr.xv	
	Ergotine,	gr.vj	
	Glycerini,	ʒij.	M.

The whole amount injected at one time; but should be glad to hear from others on the subject.

Dr. H. W. S.—1. We do not know. 2. We have never seen any evil effects from Fowler's solution administered in the doses you mention, yet we should always be on the lookout for any unpleasant symptoms, as some peculiar idiosyncrasy may exist, in which there is absolute intolerance to the drug.

Dr. L. N. D., of Ind., writes:—Have any of your readers any knowledge of deleterious results, coming from the use of the patent compound, termed "*Antifat?*" There have been two fatal cases here, of peculiar stomach and bowel ailment, in both of which this nostrum is said to have been used. Is anything known of its composition?

MARRIAGES.

FREEDLEY—BOWMAN.—On June 8th, 1880, at the bridegroom's summer residence, at Pott's Landing, by Rev. J. H. Hendricks, Samuel Freedley, M.D., of Philadelphia, and Mrs. Mary E. Bowman, of Montgomery county.

DEATHS.

CORNELIUS.—In this city, on the 15th ultimo, William S. Cornelius, M.D., aged forty-five years.

DEMME.—On the 18th ultimo, at Schooley's mountain, N. J., Dr. Theodore A. Demme, in the 47th year of his age.

LAUTENBACH.—In this city, on the evening of the 24th ultimo, Dr. B. Franklin Lautenbach.

OSBORNE.—On June 25th, at Council Bluffs, Iowa, Dr. Henry Osborne, aged 50 years.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1220.] PHILADELPHIA, JULY 17, 1880. [Vol. XLIII.—No. 3.

Original Department.

Lecture.

IV. PULMONARY PHTHISIS.

Delivered at the Philadelphia Hospital, December 10th, 1879,

BY WM. PEPPER, M.D.,

One of the Physicians to the Hospital, and Professor of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WM. H. MORRISON, M.D.

Gentlemen—To-day I wish to ask your attention to catarrhal phthisis, which is the outcome of catarrhal pneumonia, and depends upon the fact that the exudation, instead of being gradually removed by a process of softening and expectoration, passes more or less entirely into a state of cheesy change, that this has crumbled down, that the walls of the air vesicles have become involved, and thus the destructive process has been established in the lung. The first division that we must make of catarrhal phthisis is into the acute and chronic forms, and this depends upon two elements or chief reasons: first, upon the violence and extent of the original attack; and secondly, upon a weakness of the individual constitution, by which it yields more or less readily to the attack of disease. Thus, for instance, we have a form of catarrhal phthisis which, fortunately, is not very common, popularly termed galloping consumption, which is in reality a general catarrhal pneumonia, rapidly passing into a state of cheesy degeneration. In speaking thus of acute catarrhal phthisis, I do not refer at all to acute miliary tuberculosis.

This latter disease is a very rare affection. It has altogether a peculiar history and course. It is much more like one of the acute infectious zymotic diseases in its course than it is like a local affection. It has a peculiar temperature curve, a peculiar state of the nervous system and of blood intoxication, while the local signs in the lung are comparatively slight and obscure. It runs its course in from seven to fourteen days, terminating invariably in death. As a rule, it comes from the absorption of some infectious matter, from a previously existing centre of cheesy degeneration, although, in a few cases, it has exploded in an individual who has no such centre, but who has inherited a virulent degree of the tuberculous diathesis. Generally, in such cases, the disease appears early in life.

Acute catarrhal phthisis is, as I have said, the outcome of an acute catarrhal pneumonia, and runs a course whose length is dependent upon the severity of the attack and upon individual peculiarities. This affection is not recognized as constantly as it should be. This is because the physical signs are not well marked, and are not the ordinary physical signs of pneumonia, as we have come to consider it; that is, lobar pneumonia. Usually, when a patient is attacked with catarrhal pneumonia, he will not have very violent fever, marked dullness, bronchial breathing, and the other marked symptoms that we have in croupous pneumonia, and thus many cases are entirely overlooked. The affection may involve a very small area of the lung, or it may involve the whole of one lobe, or portions of both lungs.

Let me illustrate this by a case I saw a short time ago. A patient comes into my office and states that he has a bad cold, and that he had a slight rigor forty-eight hours previously. I find him distinctly feverish, with rapid pulse and res-

piration, and on examination of the chest there is found a left-sided broncho-pneumonia. Râles are heard pretty much all over the left lung. The râles are some sonorous and some sibilant, formed in the larger tubes, and indicating a process of bronchitis of these tubes. With this there are heard, in a number of points over the front and back, coarse sub-crepitant râles. Very careful percussion shows that at several points in the left lung resonance is not perfect as compared with the resonance of the points immediately around them; not that it could be called flat, but simply less resonant than over the unaffected lung.

The patient is ordered home and to bed. The disease passes on through a stage, attended by a moderate degree of fever of rather a remittent type, with a rise in the evening to 102° or 103° and a fall in the morning to about 101°; never entirely disappearing. This is attended with a good deal of perspiration; the skin is relaxed, the cheek of the affected side is flushed, and the patient loses flesh very rapidly; he becomes extremely anæmic; the tongue is foul and coated, but the appetite is pretty well preserved; the secretions are scanty, as in all inflammatory or febrile affections; the urine is scanty and high colored, and the bowels are constipated. The cough is troublesome, and is attended with considerable expectoration, at first of clear mucus, not rusty colored, but soon becoming streaked with yellow lines, and gradually more solid and purulent in character.

The physical signs remain as I have described them, except that the râles gradually become larger and more moist, and are heard over the whole of the left lung, back and front. With this there is scarcely any dullness on percussion over the lung, and it is only by very careful examination that you will find four or five points of limited size, where there is distinct relative impairment of resonance. You would be surprised at the great disproportion between the numerous râles and the amount of dullness and the absence of pure bronchial breathing.

As the case advanced, the lower portion of the lung cleared up, the râles gradually diminished, and the respiratory murmur returned; but at the apex there remained râles, which became larger and larger, until they finally became almost bubbling in character, the respiratory murmur slowly became more blowing in character; diffused, hollow, blowing breathing.

Now what has been the course of the disease in the lung? We have had originally a catarrh affecting the bronchial tubes. This has extended along the left bronchial tube until it has reached and involved the alveolar structure, and thus set on foot a broncho-pneumonia of the left lung. Such changes are very insidious in their course, and the disease may exist for a long time before being discovered.

Catarrhal pneumonia is to be distinguished from bronchitis by its unilateral character, the presence of sub-crepitant râles, the detection of small areas of dullness, by careful percussion, and by the degree of febrile action. The exudation is not of a croupous but of a catarrhal character; the walls of the alveoli have been attacked so that the cells are no longer able to rapidly get rid of the exudation. It takes a long time to accomplish this, so that at the end of six or eight weeks râles may still continue at the apex of the lung. A portion of the exudation undergoes cheesy degeneration, breaks down, and is discharged slowly.

Will it ever be removed, or will it pass into a state of catarrhal phthisis? This will depend upon the violence of the attack and the tendency of the individual. Every one is liable to an attack of catarrhal pneumonia, and in any one, owing to the causes before referred to, it may set on foot catarrhal phthisis. Of course, in a person who has a weak state of constitution, particularly if he has an inherited weakness and tendency to lung disease, or if his health has been broken down by any of the debilitating causes of which I have spoken, an attack of less severity will be able to start a catarrhal phthisis in his lung. We may have this disease running a very rapid course, and terminating in from six weeks to four or five months, with all the evidences of a catarrhal pneumonia, passing into a chronic form, with marked fever, night sweats, and breaking down of the lung tissue, and the patient slowly sinking, and finally dying. These are cases of galloping consumption, or acute catarrhal phthisis. There are one or two symptoms occurring during its course to which I shall allude more particularly toward the end of the hour.

In the more common form the disease is not usually so severe or general from the beginning; but it begins like a common cold, and is, I am sorry to say, often mistaken for an ordinary cold. The patient does not trouble himself much about it, but thinks that it is an ordinary cold, such as he has often had, and that he will be well in a few days. If such a patient was carefully examined, it would be found, instead of there being an ordinary cold, by which we mean a catarrh of the upper air passages, that there was

considerable febrile action, more than usually occurs with a simple coryza, or a simple catarrh of the throat.

On carefully examining the lungs, there would be found, at some parts, physical signs indicating a slight degree of catarrh of the small tubes and air cells. The points where you will usually find these signs are at the apex and the root of the lungs. The physical signs that, as a rule, you will meet with are such as these: in the first place they merely indicate congestion of the lung tissue, and a slight catarrh, feebleness of the respiration, with prolonged expiration, and on very deep breathing, or after coughing, you will have a few sub-crepitant râles; or there may be more marked catarrh; then we will have sonorous and sibilant râles, with more copious sub-crepitant râles; or lastly, the attack may be attended with a large amount of exudation; then there will be a slight impairment of resonance, a little difference on the affected side, as compared with the surrounding healthy lung, the respiratory murmur rather harsh and blowing, the expiration prolonged, and the râles more marked.

Now, these are the physical signs met with in a localized pulmonary catarrh, which is, in reality, a simple circumscribed attack of catarrhal pneumonia. You see that these are very slight signs, and unless the physician is wide awake and the examination very minute, they will very likely be entirely overlooked. If you simply run your ear over the chest, without removing the coat and vest, you will be sure to mistake the nature of the attack.

The febrile signs pass away in from two or three days to a week, and the patient appears to have regained his ordinary health. He has a little expectoration, which diminishes, and the cough passes into a simple, dry, hacking cough. He goes about his business and continues, for an uncertain time, pretty well. Another attack similar to the first occurs, perhaps after two months, or perhaps after a longer period. This attack is more marked, and the nature of the disease more easily determined; but I have had cases where there had been evidence of at least five or six attacks, and where their nature had never been recognized until after a period of nine or ten months, and not until the disease, which had at first involved only a trifling spot, had involved a considerable portion of the lung.

This is the history of three out of four cases of so-called consumption. They commence as ordinary colds; the patient will tell you he has a neglected cold, which has finally settled itself upon the lung. The probabilities are that this was an attack of catarrhal pneumonia, involving a small spot of the lung, and as each attack has occurred, it has involved the affected spot, causing an extension of the inflammation, until finally the exudation has passed into a cheesy state, the tissue of the lung has become involved and broken down, and phthisis has resulted.

I would, therefore, dwell on the extreme importance of recognizing the early stage of this disease, and it is only by a minute physical examination that we are enabled to tell whether a patient who has a feverish cold has a simple catarrh of the upper air passages or a slight catarrhal pneumonia. Any patient who has a catarrhal pneumonia, no matter how small the affected spot may be, is in danger of having it remain and pass into a catarrhal phthisis or develop tuberculosis. It is of the greatest importance to recognize catarrhal pneumonia, because, while it is true that, after the disease has involved a large portion of the lung, with destruction of its tissue, an entire cure is impossible, it is equally true that in the early stage, before destruction has occurred, the process is curable, in the majority of cases. It is only in those cases where the constitutional tendency or the individual peculiarity is very marked, that we find a resistance to our treatment in the beginning of the attack. I think it is no exaggeration to say that the great majority of cases of consumption are curable in the early stages. We will hereafter see how far it is curable in the later stages.

Suppose the patient does not consult us in the early stages, but after some period of time has elapsed, what will be the conditions present? I have a number of patients here who illustrate these conditions. After the acute stage has passed it leaves behind certain changes in the lung, and the patient presents certain general symptoms. Let us first study these general symptoms. They vary greatly, according to the state of the local trouble, but much more according to the individual peculiarity. Sometimes a patient with positive lesions in the lung will seem to be in ordinary health, keeping his flesh very well.

Now here is a lad who has a small circumscribed cavity under the clavicle. He had when he came in a catarrhal phthisis of the left apex, profuse night sweats, quite rapid emaciation, and marked physical signs, but no spitting of blood. The acute stage passed away, but has left behind an induration of this upper right lobe; he has gained in flesh, the night sweats have stopped, and he has the appearance of

being in pretty good health for a person who has been confined so long in a large hospital. Some patients, then, will present almost ordinary health, with scarcely any febrile action, with little cough and expectoration, and they will scarcely believe you when you tell them of the local disease in the lung. More frequently you will find that such patients present a history of recurring febrile attacks.

Now, for instance, this man, Fisher, who has a catarrhal phthisis of the whole upper lobe of the right side, with only small centres of disease scattered throughout the lobe, not giving rise to any marked dullness, but causing impaired expansion of the upper part of the right lung, weakness of respiration, prolonged expiration, and on coughing or deep breathing slight mucous râles, indicating that the lung has passed into a state of degeneration, leaving, I fear, little ulcerated spots, has presented in the highest degree these occasional febrile attacks.

If while he is feeling perfectly well a change of weather occurs, or he makes some unusual exertion, or sometimes without any apparent cause, he will have a little creep, followed by fever. He will feel a little sick and lie down, but in the course of twenty-four hours he again feels better. He has more cough, and examination shows the physical signs to be more marked. I suppose that since he has been under my observation he has had eight or ten of these attacks. Such attacks are highly characteristic of catarrhal phthisis in its chronic variety. The patients become so susceptible to any disturbing cause that they will have such attacks even under the best of care, and with every attack you will observe that there has been a fresh development at some part of the lung, usually around the affected area. These occasional febrile attacks the patient ascribes to fresh colds, and there is a certain amount of truth in this, because there is, with each attack, an extension of the catarrhal process.

During the whole course of the disease there is apt to be some irregular febrile action. This varies much in different persons; for instance, this patient is almost entirely free from fever; this next man has more marked febrile action, with a morning temperature of 98° and an evening temperature of 99.5°; while this one has a continued febrile action, and his morning temperature is never down to normal. As the disease advances and the system becomes more and more broken down the fever assumes a marked hectic type.

I have now a patient under my care, with catarrhal phthisis, in whom the morning temperature is never below 102°, and the evening temperature 104°, 105°, or 107°. I have found her sitting up in bed, feeling pretty comfortable, with a temperature of 107.5°; but, of course, this high fever is only seen in exceptional cases, where the system is strongly predisposed to fever, or where the local process is highly irritating.

With this fever we are very apt to find night sweats, and popularly, these are regarded as certain signs of the existence of consumption. As a rule, however, night sweats are only an evidence that the patient has had hectic fever, and that after the fever there has been a crisis, accompanied by sweating. Generally, they are not very injurious, but sometimes they are excessively profuse, and thus cause exhaustion. Thus, in the lad, the fever was not very high, but the night sweats were very obstinate, and resisted almost every known remedy for that condition. Sometimes, after a patient has recovered from a catarrhal attack, he is very much predisposed to profuse sweating. When this occurs, it is a very significant symptom. I have repeatedly had patients, who were suffering from night sweats in a very marked form, tell me that some years previously, after getting a slight cold, they had troublesome night sweats for three or four weeks, which had been stopped by treatment.

You will occasionally meet with cases in which the hectic fever and night sweats are so pronounced that they mislead you as to the nature of the trouble. You may mistake it for malarial fever. Sometimes the patient will tell you that he was perfectly well until he had an attack of chills and fever. On examination, you will find that he also had a little cough and expectoration. In such cases the patient has had a slight catarrhal pneumonia, with the hectic fever and sweats well marked; but after the attack has passed into the chronic form the chills and fever have become more moderate. Hence, when a patient presents a history of an apparent malarial attack, and if he has a slight cough, you should study the lungs very carefully. Night sweats are then a frequent symptom of phthisis; but, as a general rule, they are not to be regarded so much as causing harm as the hectic fever which causes them.

All these patients present marked anæmia. There is great impairment in the power of the blood-making apparatus. They lose the power of keeping up their circulation under exposure, and are apt to have cold hands and feet, although you will often find that the palm of the hand burns with a hectic flush. You will also usually

recognize the well-known hectic flush upon the cheek, which gives a deceptive appearance of health.

Loss of flesh is a very constant symptom, much more so than you would think if you believed what your patients tell you, for they will often insist upon it that they are keeping their weight. In some of these cases there is a strange blindness on the part of the patient as to his true condition. There is only one way to determine the question, and that is to weigh the patient yourself. I long ago adopted the plan of weighing my phthisis patients at short intervals, in order that I might know the effect of phthisis upon this point; and as a matter of fact, I think you will find that no one symptom is more worthy of study or more important as showing the condition of the patient, than this variation in the weight. If a patient, although his cough and expectoration continue unchanged, is slowly gaining in weight, I think it is a most favorable sign; but if a patient continues to lose weight, while the other symptoms improve, I consider it an unfavorable omen. This loss of flesh is sometimes very rapid, rendered so by the high degree of fever, the copious purulent expectoration, and the intermittent attacks of diarrhœa, of which I shall speak more particularly in a few minutes. Sometimes it is very slow, and the patient will keep his weight for some time.

Loss of strength and shortness of breath is always presented by these patients. They give out on the least exertion, and this exertion causes considerable shortness of breath. The shortness of breath is caused partly by loss of power in the respiratory muscles and heart, and partly by the actual crippling of the lungs; but when the patient is quiet you will be amazed to find how little they suffer from shortness of breath. I do not suppose that one of these five men before you suffers from any conscious shortness of breath. This seems to be due to the fact that, as the lung is involved, there is a corresponding wasting of the solids and of the blood, and a corresponding diminution in the chemistry of the body; there is less blood to be oxidized, and consequently a smaller amount of pulmonary tissue suffices.

Cough is a very constant symptom; few patients are free from it, but I have had patients come to me and say that they have not coughed for several months. The cough of catarrhal phthisis varies according to the stage of the disease. In the early stage, during the acute attack, the cough is troublesome. This subsides and becomes of a hacking character, occurring at short intervals, but frequently leaving the patient free at nights. As the disease advances, and the exudation breaks down, you will find that the cough becomes more severe and harder, and is apt to occur especially at certain times of the day, particularly if a cavity has formed, which fills up, and coughing comes on, and it is emptied. This may occur with the regularity of clockwork. When the cough is hard and spasmodic, particularly when matter is raised from the lower part of the lung, it may excite vomiting, which may prove a troublesome complication.

The matters expectorated are, in the early period of the case, simply catarrhal products and clear mucus; as the disease progresses they become streaked with yellow, and later they acquire a solid, yellow character, floating in a certain amount of bronchial serum or mucus. It is impossible to determine the state of the lung from the character of the sputa, for sputa having all these characters may be produced at any stage, because, while the lesions at one part may have reached the final stage, they may at another point be just beginning. The patient may have a severe phthisis, and raise very little, while another with a small amount of disease may raise a large amount. We must, therefore, conclude that a large amount of the expectorated matters come from the bronchial mucous membrane.

In many cases you will find that the patient complains of local pains about the chest. These apparently depend upon small local attacks of pleurisy, or sometimes upon attacks of muscular rheumatism, to which such patients are exceedingly liable, on account of the relaxation of the whole system.

There are certain special symptoms which may occur during the course of phthisis, to which I will now allude. The first of these, hæmoptysis, or spitting of blood, is a symptom universally dreaded, and always regarded as a certain sign of consumption; but I know of no symptom whose significance is so much misunderstood. There is no difficulty in recognizing when a patient has hæmoptysis; the character of the blood and the way in which it is raised will indicate its origin; but it is very difficult to decide upon the precise spot from which it comes. Undoubtedly, in the larger number of cases, it comes from the bronchial mucous membrane, especially of the smaller tubes. In other cases it comes from the capillaries of the lung. In others from a vessel of considerable size which has been opened by ulceration.

In what condition does it generally take place? We notice it in many cases at the very beginning of the attack. Now, as long as it was the habit to say there was a deposit of tubercle in the lung, and the irritation from this deposit caused the hæmoptysis, hemorrhage was regarded as a sign of tuberculosis of the lung; but as a matter of fact, those cases that have hemorrhage are least apt to have tubercle. In tubercle, as I have described it to you, no blood vessels exist; no anatomist has been able to discover any capillaries in it, and when it forms in the wall of a blood vessel a clot forms, and the vessel is closed. Where you meet with hæmoptysis in a person who has been apparently well, you will find that it usually occurs from an acute attack of catarrhal pneumonia or congestion of the lung.

We thus see that hæmoptysis is most frequently an evidence of acute congestion or acute catarrhal disease, and that it generally occurs at the very beginning of the attack, and that when it appears during the progress of the chronic form it will usually be found that each attack of hæmoptysis marks an acute extension of the disease.

I have a few more remarks to make in regard to hemorrhage, which I shall defer until we meet next week.

Communications.

THE SUMMER DISEASES OF CHILDREN.

BY WILLIAM B. ATKINSON, A.M., M.D.,

Lecturer on Diseases of Children, Jefferson Medical College, Philadelphia.

During the intense heat of the summers of the United States few children entirely escape without a more or less aggravated attack of what was formerly familiarly known as "the summer complaint," now so commonly called "cholera infantum." This ailment generally attacks children about the time of their first dentition, or from the sixth month to the eighteenth. It is rarely met with after the age of two years. It generally commences its ravages about the first of July and continues with greater or less severity until the approach of cool weather in October. Much, however, depends upon the suddenness of the accession of the heated term. The author has met with one well-marked, nearly fatal case, this year, early in April, on the occasion of one or two days of great warmth.

While it is extremely prone to attack hand fed children and those who, by reason of poverty, are exposed to impure air, as by over crowding, ill-ventilation and filthy surroundings, yet it is by no means confined to these classes, but may and frequently does attack the nursing children of those who are placed under the happiest auspices as to fresh, pure air and the best hygienic conditions.

Again, even where it would appear as though the hygienic relations were especially fitted to favor the production of this disease, it constantly occurs that children so exposed entirely escape an attack. The author has so frequently observed this, that he is forced to the conclusion that there are several factors in the causation of this disease other than filth, heat, and improper food. Perhaps one very great aid in the prevention of attacks in these cases is the fact that these children live almost entirely in the open air during the daytime. Bad as may be their surroundings, there is a constant infusion of fresh air, which, though it may not be of the purest, yet aids in diluting greatly the poison emanating from the filth, etc. Children so exposed from very early infancy, and in the healthier seasons, are thus rendered less pregnable to disease, or when attacked are less severely affected.

From these views it will readily be seen what may be done in the way of preventing the occurrence of the disease. Chief among these measures will be the early removal of infants, at the critical period, from the heated atmosphere of a great city to the country, or preferably to the seaside. Nor is this only of value as a means of prophylaxis, but it constantly serves to cut short an attack, and even, in many instances, the author has seen a removal to the seaside followed by a speedy recovery, where the little patient seemed almost beyond hope. Where such removal is impracticable, the next best plan is to take the child on the water daily, as can readily be done by means of the numerous ferry boats plying constantly on the rivers on which our large cities are generally located. Or to keep the child from an early hour in the open air, until the intense heat of midday commences, and again in the afternoon, as the heat begins to decline. For this purpose the numerous parks are of great value, and when these are at too great a distance, recourse must be had to any open space where sufficient shade can be obtained.

When the child is nursing, the diet, during the heated term, should never be mixed, but it should be restricted solely to the breast milk. Where the child is artificially fed, too much attention cannot be given to the utmost cleanliness of the nursing bottle, the avoidance of adulterated or sour milk, the overloading of the stomach,

and the prevention of violent motion of the child soon after feeding. If we add to this, perfect cleanliness of the child, non-exposure to the direct rays of the sun, care as to its general surroundings, and the use daily of the tepid bath, we give our little patient the best chances for immunity from an attack.

Cholera infantum may commence abruptly, or may be preceded by a diarrhœal stage. The latter is by far the most commonly observed. For several days the bowels are loose, the evacuations quite thin and of a yellow or pea-green color, and in other cases nearly natural in color but of a watery appearance. This may continue for several days, and suddenly there occurs an explosion of the disease, heralded by very frequent stools, consisting almost wholly of water, often colorless and without odor, and along with this there ensues great irritability of the stomach, so that it almost instantly rejects everything that is taken. This irritability speedily extends to the lower intestine, so that the evacuations are actually squirted from the anus, often in a frothy state. Where the preceding diarrhœa has existed for a time, emaciation has gradually occurred, but when the attack is sudden, it is remarkable with what rapidity the child assumes the appearance of one that has been sick for a long time. Within a few hours it comes to look like a little "old man," with pinched features, sunken cheeks, hollow eyes, the fingers long and bony; in short, it presents every symptom of an extremely rapid abstraction of the fluid constituents of the body. In no way can we be enabled so readily to appreciate the fact that the fluids are so greatly in excess of the solids in the human body as when we see one of these shriveled little mortals, a living skeleton, eagerly demanding fluids, which are almost instantly rejected. In many instances, the change of a few hours is so great that even those constantly in attendance upon the child fail to recognize a familiar feature.

The progress, unless fortunately checked, is now rapidly downward; the dejections soon become almost clear water, and pass away involuntarily; the child lies motionless, or with an occasional fretful fling from side to side; there is the most intense thirst; fluids are swallowed with eager haste; there is little or no pain; great acceleration of the pulse without force; the eyes remain half closed, the lips parted; coma sets in, and death soon closes the scene.

One great peculiarity of the stools is their entire want of odor, or the presence of a musty smell, which is very offensive, and the presence of minute flocculi, so as often to give them the appearance of rice water; hence the name rice-water discharges. As a general rule, the urine is scanty, and often is wanting.

In the early stages of the attack the temperature usually runs high, perhaps as high as in any disease of childhood, 105°-107°, but reduction of heat rapidly ensues, commencing at the extremities, the abdomen and head being the last parts to yield and become cold.

Death usually occurs from exhaustion, and the child dies without an effort, though in some instances the irritation seems to extend to the brain and spine, and convulsions occur, or the child burrows with its head in the pillow, rolls the head from side to side with a monotonous, distressing motion, apparently unaware of what it is doing, and at intervals utters short, sharp cries. Even at an early stage it is frequently the case that the child shows its irritability by a peculiar cry, which, once heard, is apt to impress the attentive physician as the herald of some dangerous complication.

Epidemics of this disease differ in many ways. In some it seems to assume a very acute form, so that the majority of deaths occur within twenty-four to forty-eight hours. In others it is more chronic though not less fatal, and the case may be prolonged for several days or a week. Where the special symptoms abate, the disease becomes nothing more than a diarrhœa, but attended with great debility.

The differential diagnosis between this and similar diseases of children is made by the peculiarity of the stools—thin, watery, soon becoming colorless and odorless, or musty, irritability of stomach, great thirst, rapid emaciation, etc.

The correct treatment of cholera infantum is of great importance, inasmuch as thus a large number of cases may be saved which appear at first hopeless, or which by careless or inappropriate management would rapidly drift down to death.

The most prominent symptoms imperatively demanding immediate relief are the irritable stomach and the exhausting evacuations. To relieve the one and arrest the other, therefore, will be the primary indication. For the first, the persistent vomiting, the exhibition of small doses of calomel, say one-twelfth to one-sixth of a grain, repeated every hour, will almost invariably suffice. It will be best given placed dry on the tongue and washed down with a sup of milk, or some bland mucilaginous drink. Frequently, this so speedily relieves that the whole scene is changed, and often the diarrhœa is equally

checked. No doubt, this latter symptom is, in many cases, more or less continued by the efforts of the child in vomiting, and that quieted, the bowels experience less perturbation.

In this connection, it must be remembered that *rest in the recumbent position* is of great value, and this should be strongly impressed upon the attendants, who, by their mistaken though kindly meant treatment of the child, materially aid in keeping up a condition which is rapidly carrying it to the grave. When the calomel fails, the use of small doses of dilute sulphuric acid will often serve to put an end to the vomiting:—

℞. Acidi sulphurici dil., gtt. xl
Syr. simplicis, f. ℥ j
Aq. menthæ viridis, f. ℥ ij. M.

Dose.—One teaspoonful every half hour or hour.

To aid our remedies we may employ some form of warm fomentation to the stomach. Or, by producing a positive redness of the surface of the epigastrium, by means of a mustard plaster, great relief is frequently obtained. Other and very useful methods are poultices of hops, spice plasters, and the application of a few leeches to the surface of the epigastrium.

Additional medicaments are chloroform, in drop doses frequently repeated, mixed with mucilage of acacia and a little syrup, followed immediately by the application of a small piece of ice in a cloth, so that it may slowly be dissolved; small doses of camphor dissolved in ether; or powders of the subnitrate or subcarbonate of bismuth.

To arrest the frequency of the discharges, a very useful remedy is the bismuth, in five to ten grain doses, with the compound powder of ipecacuanha:—

℞. Pulv. ipecac. comp., gr. iv–vj.
Bismuthi subnitrat., ℥ j. M.
Ft. in chartulæ, No. xij.

Dose—One every two to four hours, according to circumstances.

Where the exhaustion is great the bismuth may with much advantage be combined with the aromatic spirits of ammonia, which is a most excellent stimulant in all cases of exhaustion in children; or it may be given separately while the bismuth is continued, with or without the ipecac. powder. In employing any narcotic, paticularly opium, great watchfulness must be observed as to its results. It is always contra-indicated where the disease is complicated with brain symptoms. Give it in small doses, with care, and withdraw it as soon as the evacuations are checked, or if necessary, continue it in greatly reduced doses. For children, the camphorated tincture of opium is preferable to the tincture.

The diet must be mainly milk, with lime water, beef tea, mucilaginous fluids. Brandy or whisky should be added from the outset, and continued in small but frequently repeated doses, until recovery has proceeded so far as to render stimulation unnecessary. To relieve the intense thirst ice in small pieces may be rubbed over the gums and allowed to dissolve in the mouth, or a teaspoonful of cold water, at short intervals, may be given. The child should never be allowed to suffer for want of it.

Frequent sponging with alcohol and water, or tepid water alone, will prove advantageous. This is better than the use of the bath, as the necessary movement of the patient is liable to add greatly to the exhaustion, or to induce it. In addition to these measures, there must be the most scrupulous attention to ventilation and cleanliness. Never allow the child to remain in an overcrowded room; better that it should sleep in the open air night and day.

Perhaps a most fruitful cause of bowel affections in children, and also in adults, is exposure to a draught at night, or rather toward morning, when the temperature is usually at its lowest. In their restless tossing, by reason of the heat, they become completely uncovered, and so lie exposed; the legs and abdomen are chilled, producing congestion of the bowels, and a diarrhœal attack ensues.

Regarding cholera infantum as usually, if not invariably, the result of congested bowels, good effects have been observed after the employment of a positive counter-irritant to the surface of the abdomen, and also to the whole length of the spine. The best rubefacient is a liniment composed of ammonia, turpentine and castor oil:—

℞. Liq. ammoniæ, f. ℥ ij
Ol. terebinthinæ, f. ℥ ij
Ol. ricini, f. ℥ iv. M.
Ft. linimentum.

Rub the abdominal surface and the spine briskly with this, so as to redden the skin, and repeat about every two hours. In many instances immediate good results follow, and the patient rapidly convalesces.

As the case progresses tonics may be given, to aid the recovery of strength.

Quinine is especially the children's tonic, is readily tolerated, and rarely fails to prove of value. As a tonic for weak bowels, the solution of nitrate of iron cannot be excelled. It is best combined with a vegetable bitter.

In those cases where the progress is less favorable, where the brain becomes involved, it will be necessary to employ cool or cold applications to the scalp, and this may be best done by the use of the ice cap, ice in a rubber bag or a bladder, or pieces of ice in a folded towel. At the same time, hot pediluvia, sinapisms or rubefacients to the lower extremities, will aid in inviting the blood from the brain. It must not, however, be forgotten, that cerebral symptoms may be simulated by exhaustion, for which the proper treatment will be more positive stimulation and larger doses of quinine and iron in some form. Blisters in very young children are always a remedy of doubtful value. Often they do not seem to produce sufficient advantage to compensate for the annoyance they give the little sufferer. A blister should never be placed upon the nape of the neck, as we thus inflict upon the child a terrible punishment, compelling it to lie almost wholly upon its face, in order to escape the irritation caused by the rubbing and pressure of the blistered surface upon the heated pillow. When deemed absolutely necessary, they may be applied behind the ears, and most easily by means of the blistering collodion.

Where there exists positive evidence of cerebral congestion, a better plan will be the application of two or three leeches to the temples, being careful not to allow the bleeding to continue too long, and thus complicate the case further. After this the cold applications may be continued as indications present.

For great restlessness, and to insure a good sleep, bromide of potassium or sodium, and chloral may be given without hesitation, and with the expectation of good results.

Finally, never despair of a happy issue, as we constantly see cases, apparently desperate, recover, as if to confound our evil prognostications. Persevere judiciously, but earnestly, until death itself prevents further efforts.

With convalescence, it must constantly be borne in mind that relapse is extremely liable to occur. Therefore, eternal vigilance will be necessary in the diet, ventilation, clothing and exposure.

To be continued.

Disguising the Taste of Epsom Salts.

According to the *Gaz. des Hôp*, June 12, 1880, the *purgatif Yvon* consists of sulphate of magnesia twenty grams, water forty grams, and essence of mint two or three drops. The essence of mint completely masks the disagreeable taste of the sulphate, providing that the quantity of the vehicle is inconsiderable.

WEAK EYES.

Read before the Medical Society of Cecil County, Md.,

BY HENRY S. SCHELL, M.D.,

Surgeon to Wills Hospital.

The term *weak eyes* is generally used to denote such eyes as cannot be used without pain or discomfort, but in which there is no obvious sign of disease or of failure of vision.

The subject of weak or irritable eyes is one of considerable latitude, and I propose to divide all cases coming under this head into two classes.

1st. Those arising from causes immediately connected with the eye itself or with its appendages, and 2d. Those arising from sympathy with other parts of the body. The former is exclusively ocular, the latter reflex or constitutional in its origin. The first comprises a narrow domain, of difficult surface, which can only be cultivated to advantage by the aid of instruments of precision, and within which the tendency is to abandon more and more every day to the tillage of the specialist. The last include a far wider range, and although the great landmarks are often first pointed out by the ophthalmologist, the ground really belongs entirely to the general practitioner. As there is, however, no hard and fast line separating the functions of these two laborers in the medical estate, it is possible that in considering the cultivation of "fresh fields and pastures new" they may often be of mutual assistance to one another.

The weak or irritable eyes of the first of these two classes may be again profitably divided into three main varieties, in relation to their causation, viz: into those arising, 1st, from anomalies of refraction; 2d, from failure of the mechanism of accommodation, and 3d, from inflammatory conditions. Those of the second class are divisible into two varieties: the first of which is manifested by a partial or complete paralysis of the nerves of accommodation, and the second, by paresis of the vaso-motor nerves of the interior of the eye.

I propose to pass these several varieties in review, and to invite attention to the means by which they may be distinguished from one another, in a general way, even without the aid of the ophthalmoscope. In the first place, then, concerning *anomalies of refraction.* These are, with perhaps the exception of myopia, mostly congenital. They may make their presence evident in early childhood, with the first attempt to learn letters or to use the eyes upon some close work, or they may lie dormant and only declare their presence at the age of fifty or even sixty years,

when increasing hardness of the crystalline lens renders futile the efforts of the ciliary muscle to neutralize an abnormal curvature in the cornea. In asthenopia of this sort the patient gives the following history of his troubles: He says that in commencing to read he at first sees the letters distinctly, but they sooner or later become blurred and run together. If he closes his eyes for a few minutes and tries again, the same experience is repeated. If he then strains hard to see, he perhaps succeeds, but it is at the expense of feelings of pressure and fullness in the eyes, and of tension in the forehead. A continuance of the effort brings on pain in and around the eyes, headache, giddiness, and even nausea and vomiting, together with a sensation of dazzling, some lachrymation and injection of the conjunctiva. This state of affairs may have existed for some time, and the symptoms may have gone on from bad to worse, before the patient applies for relief, and we may then find him with contracted pupil, chronic hyperæmia of the tarsal conjunctiva and hypersecretion of mucus, simulating a catarrh. At this stage of the affection the patient is much troubled with intolerance of light, and especially the glare of gas or other artificial means of illumination. Styes are apt to make their appearance along the tarsal borders, and meibomian cysts to form in the substance of the lids. The patient, perhaps a clerk, an expert penman, dependent upon the use of his eyes for a livelihood, now begins to think seriously of abandoning his occupation and of beginning life anew, by searching for another, wherein accurate eyesight will be of less importance to him.

All the painful symptoms in these cases are at once alleviated by the use of atropia, which puts near work out of the question, sets the eye at rest and prepares it for an accurate examination of the refraction. It is not, of course, necessary, in such cases, to subject every eye to the temporary indistinctness of vision which atropia produces, but wherever there are clear indications of the existence of astigmatism, it will usually be, in the end, the best course to pursue. The only permanent relief in all these anomalies of refraction is to be gained by the careful adaptation of proper glasses, and, if necessary, by the gradually increasing exercise of the eyes before using them for continuous work.

I have said that anomalies of refraction sometimes first disclose their presence as late as at the sixtieth year of age, and, indeed, it is not very infrequent to find persons beyond that age applying for relief from asthenopic symptoms. These individuals have generally been wearing glasses for years, changing frequently from one pair to a stronger, until at last, from orbital pain and irritation, they find themselves unable longer to read for any length of time. A still stronger pair of spectacles, from the optician, enables them to see, by enlarging the retinal image; but a strong glass means a short focus, requiring close approximation of the object under examination, and the internal recti muscles soon falter under the fatigue of forced convergence, and the sight becomes blurred again. Such cases will usually be found to require a combination of a cylindrical lens with a spherical one of much less power than that of the one they have been accustomed to wear.

The second variety of weak eyes from intra-ocular causes, blends at its edges insensibly with the first. For, though the failure of accommodation, through senile hardening of the lens, first shows itself, in the normal or emmetropic eye, between forty and fifty years of age, yet the same indurating process really commences very early in life, and goes on, increasing gradually throughout. So that if there is any complication of hypermetropia or astigmatism the effects may appear much earlier. The attempt to evade the use of glasses in these cases generally produces precisely the same set of symptoms as those previously described.

In most inflammatory conditions of the eye, which constitute the third variety of this class, there is usually a frank exposure of their presence, by reason of the injection of the ocular conjunctiva which accompanies them. But, occasionally, this symptom is absent, and the most obvious condition appears to be that of weak sight. In these cases, in addition to the ordinary painful or uneasy sensations which arise when an attempt is made to use the eyes, there is always considerable intolerance of light; this being, perhaps, the most prominent symptom, and it will be found that the disagreeable feelings and asthenopia do not disappear after prolonged rest. Indeed, the eyes often feel worse on first waking in the morning than they did the night before. Inflammation often lurks undetected in the conjunctiva of the upper lid, but is liable to betray its presence there by an increase of the mucous secretion, and if the patient is closely questioned, he will remember that his eyelids have a tendency to stick together in the mornings.

It is well, as a matter of routine, to evert the upper lid, and examine its inner surface, in all cases where weak or irritable vision is the subject of complaint. Of course, in those cases the treatment will depend upon the tissue implicated,

the amount of inflammation, and other circumstances which it is unnecessary to discuss at this time.

But it is the fashion of the day to lay too much stress upon local conditions as causes of weak eyes, and especially to attribute too great an influence to trifling anomalies of refraction. The minutest defects of this kind, divergences from mathematical accuracy of focusing, which are yet perfectly within the limits of emmetropic variation, have been supposed to account for the most distressing asthenopic symptoms. In consequence of this an epidemic of spectacles has ravaged the community. No sooner is one person affected than the disease spreads through the whole family, and pretty girls in their teens are transformed into strong-minded-looking women, behind an armor of glittering glasses. It is no uncommon thing to find a patient going from one oculist to another, getting a new prescription for spectacles from each, and always without relief. Much of this condition of affairs is no doubt due to a mental myopia on the part of the practitioner, and results either from an exclusive devotion to a specialty at too early a stage of the professional career, or from the attention being narrowly riveted to the organ under discussion, to the neglect of the rest of the system. The practice of a specialty should be an attribute of ripe experience, not of the beginning of real study. The eye is not a separate entity, which can be detached from the body and live, but an inseparable part of the whole individual, and if we have a sick eye to treat we want to know, not only what is the matter with it, but everything that bears adversely upon the health of the person to whom it belongs.

This brings us to the consideration of the second division of our subject, viz.: those cases in which the weakness of the eyes arises from sympathy with other parts of the body. The cases are, as I said before, of two varieties, both affecting the nervous supply to the interior of the eye. In the first variety, those filaments of the third nerve which control the mechanism of accommodation are more or less completely paralyzed. The eye readily becomes fatigued when used; in reading, the letters presently run together and are illegible; all objects look smaller than natural, and a continuance of the effort to use the eyes brings on most of the series of asthenopic symptoms already related. When the eye is closely examined it will be found that the pupil is somewhat dilated; that it does not contract under efforts at near vision, and in some cases, not even under the influence of light. In addition, the iris is more or less tremulous after or during quick movements of the eye. This condition occasionally arises from caries of the teeth, in children, and especially in girls of from 10 to 20 years of age, no doubt owing to the greater excitability of the nervous system in the sex. The anatomical connection may be traced through the ganglionic filament of the first branch of the fifth nerve to the lenticular ganglion which is in communication with the third nerve by its short root. Several teeth are usually carious in these cases, and there is always a history of a good deal of toothache. The application of the extracting forceps, or better still, whenever practicable, the careful attention of a dentist, usually insures a cure, although at times the acquired inertness of the muscular fibres in the ciliary body and iris needs to be overcome by galvanism before the cure is complete.

Acute swelling of the cervical glands sometimes produces temporarily the same condition, probably through pressure on the auriculo-temporal branches of the fifth nerve, and thence, by reflex action, through the route designated above.

Disease of the ear, too, not infrequently produces the same effect. It mostly arises in those long-standing cases of inflammation of the tympanum where there is loss of the membrana tympani, with constant muco-purulent discharge, and, like a wounded and flying picket guard, gives reliable information that the outposts of the nervous system have been attacked. I have just such a case under treatment at the present writing. The patient, a young man of twenty-one, came to me a couple of months ago with the complaint that for the past year he had been growing blind in the right eye. Upon examination I found that his acuity of vision in that eye equaled $\frac{20}{xx}$. In the left it was $\frac{20}{xv}$. The right pupil was considerably dilated, and did not contract under attempts at near vision or the influence of light. Accommodation $\frac{1}{18}$. Left $\frac{1}{5}$. The ophthalmoscope showed the refraction to be emmetropic. Further investigation disclosed a purulent inflammation of the middle ear, which had lasted since he was three years of age. Under proper local treatment directed to the ear the discharge has almost entirely ceased, and the remains of the membrana tympani and the walls of the tympanum are returning to their normal condition. *Pari passu*, with these changes the condition of the eye became ameliorated, until at present the pupil is precisely like its fellow. The accommodation has risen to $\frac{1}{8}$; V. $= \frac{20}{xv}$; and he is no longer conscious of any defect in the organ.

In addition to these local causes, the same condition not unfrequently arises in consequence of such general affections as diphtheria, lead poisoning, uræmia, and alcoholism. In these cases, however, the local break down is only part of the general wreck of the system, and the question of local repair is subordinate to the problem of getting the entire vessel safely floated into smooth water and thoroughly renovated and made seaworthy again.

In the second variety of this class there is a vaso-motor paresis, affecting especially the retinal vessels, and perhaps those of the other inner coats of the eye. The symptoms are again those of asthenopia, as previously detailed, with the addition of some peculiar features, however. The aching sensations are apt be more constant and causeless, and less relieved by rest, than in anomalies of refraction. Such cases cannot look fixedly for any length of time at any object, whether near or remote, without exciting severe pain in or about the eye. The patient also complains often of a sensation of dazzling, and of objects moving, especially the floor or ceiling, when the eye is turned quickly toward them.

The turgid condition of the retinal vessels which exists in these cases can, of course, be ascertained by the employment of the ophthalmoscope only; but the unaided eye may generally discern one or two enlarged veins coursing over the white sclerotic, reminding one of a similar appearance in glaucoma; and notice also the readiness with which the ocular conjunctiva becomes flushed upon the slightest exertion of the organ of vision. The vaso-motor paresis seems to be reflex and mostly dependent upon disorder of the genital organs. The third root of the lenticular ganglion is a slender filament derived from the cavernous plexus of the sympathetic, and one of the branches of the ganglion is a small filament which penetrates the optic nerve, along with the arteria centralis retinæ, to supply the walls of the retinal vessels. Other branches follow the ciliary arteries. The path, therefore, from the pelvic plexus of the sympathetic is an almost straight road, and disturbances in the circulation of the pelvic organs produce a wave of vessel dilatation, which travels over this path, and produces a relaxed and turgid condition in the correlated area of the retinal and other ocular vessels, for it is well to remember that the veins also of the retina have a muscular coat. This distention of the retinal vessels can be seen with the ophthalmoscope, but the condition of those of the choroid is concealed by the pigment cells, and must be taken for granted. Now, whenever this condition of vaso motor paresis obtains in a sensitive organ, then also we have pain, from the stretching of already tense tissues. An analogous condition may be seen in the earache which occurs in young children, in connection with difficulties of dentition. Here the irritation travels from the inflamed gum, by way of the dental branches of the fifth nerve, through the otic ganglion, to the sympathetic filaments upon the tympanic branch of the internal carotid artery; producing that congestion of the membrana tympani which will always be found if the ears of any child with earache are examined under such circumstances.

Much of the pain which often accompanies asthenopia, from anomalies of refraction, no doubt arises from the same condition. For in these cases the pupil is contracted and the retinal vessels dilated, showing paresis of all the branches of the lenticular ganglion. But when the disturbance is reflex in character, and arises from morbid conditions of other organs, the paresis is, so far as I have seen, confined to the vaso-motor nerves only.

The irritation which particularly affects the eye in this manner is that which is transmitted from the uterus in women and from the prostatic gland in men. Three-fourths of the cases, however, occur in young unmarried, or if married, in childless women. There is often an element of apparent unreality mixed with the symptoms, which makes the case appear to border upon hysteria. In one instance, I remember, the patient, an unmarried woman of twenty-three, always averred that she could not lift her hand above her head without bringing on severe pain in the eyes. Here, in addition to a uterine catarrh, the general health was below par. A girl of nineteen came to me several times with the complaint that she was growing every day more and more near-sighted. Careful tests with trial glasses, however, always showed that she was emmetropic and had the normal acuity of vision. She had uterine catarrh, menorrhagia, a consequent lack of nervous tone, and all the train of ocular symptoms heretofore described. In many of these cases, however, the general health of the patient appears to be as good as the average. In some cases which I have met with among men, the prostate, or at least those parts about the neck of the bladder, appeared to have become irritated, in consequence of indulgence in excessive venery. The health of these men was usually, otherwise, fairly good, but they were unable to use their eyes in ordinary avocations, in consequence of their irritability. Accurate correction

of refraction errors, which sometimes co exist, affords no relief, and cure is only obtained by treatment directed to the condition of the prostate. In treatment I have relied upon cold sitz baths, cold clysters, opium, or other sedative or narcotic suppositories, perineal leeching, in exceptional cases, and sometimes the use of a succession of small perineal blisters. Some cases occurred in men who were accustomed to masturbation. Here the entire urethra was excessively sensitive. The introduction of a metal bougie—which may be passed with little or no discomfort in a healthy urethra—gave rise to apparently the greatest suffering. The pain is evidently most acute when the sound reaches the prostatic region. The introduction of such metallic sounds and their retention for five or ten minutes, I regard as a very important remedial measure. The same condition of the eyes arises sometimes in boys below the age of puberty, who are affected with phymosis and retention of irritating smegma. Circumcision is the remedy in such cases.

Little girls, too, are sometimes affected with weak and irritable eyes, which can be traced only to a state of chronic irritation of the vulva, clitoris and vagina. Sedative and astringent washes are here indicated, with perhaps cauterization of the clitoris with argentic nitrate.

As constitutional measures bearing upon the local condition, especially in men, I have found much satisfaction from the use of potassic bromide in large doses, the fluid extract of ergot, and in women, the oxide of silver.

In relation to the diagnosis of the different varieties of weak eyes which have been under consideration, I would say briefly, that when the irritability is dependent upon anomalies of refraction or presbyopia the annoyance subsides when the visual organ is placed in a state of repose.

When dependent upon inflammatory conditions of the eye or its appendages, intolerance of light is a marked symptom, and rest does not entirely relieve.

In reflex paralysis of the accommodation the partial dilatation of the pupil and its refusal to contract during near vision or under the influence of light is pathognomonic.

And in vaso-motor paresis, sympathetic with disturbance of the genital organs, the pain is more or less constant, irrespective of work, and the appearance of one or two enlarged veins meandering about in the ocular conjunctiva gives a clue to the real condition.

To amblyopia, or dullness of sight, it is only necessary to allude in order to distinguish it from the subject under discussion. In amblyopia, pure and simple, there is no pain; only failure of acuity of vision. The optic nerve itself is affected, and its action may have been impaired from reflex influences or from local causes. But a continuance of this subject would be out of place at the present time. In order to make this paper as short as possible I have thought it best to give only general conclusions and results, thus avoiding a tedious recital of cases from my note books. Such cases would have presented a strong family likeness to one another, and often have differed only in unimportant details of names, ages, and in such features as I have already indicated.

Hospital Reports.

HARTFORD (Conn.) HOSPITAL.

REPORTED BY JAS. P. HOLT, M. D.

Prevailing Diseases and their Treatment, with Report of Cases.

The most common diseases that occur in the hospital are phthisis, intermittent fever, and alcoholism. They do not present any local peculiarities.

The treatment for intermittent fever consists in the administration of cinchonidia sulph., in doses of from ten to fifteen grains, before the chill, and the continuation of five grains three times a day. This method usually controls the disease at once; if not, the ten or fifteen grain doses are repeated before the time of the next chill, about one hour. During the chill stimulants are given moderately, and hot bottles applied. Constipation is present in a majority of cases, and the pil. cathartic co. is given. This treatment generally suffices in nearly every case; occasionally a case continues in spite of treatment. We have found that the hot air bath, given for an hour just previous to the time for the chill, controls the case where other treatment has failed. Other cases have been treated with three-drop doses of Fowler's solution successfully, where cinchonidia sulph. has failed. The ordinary house diet is given.

The treatment for alcoholism consisted in the administration of beef tea, with capsicum, milk, eggs, hydrate chloral, potassii bromide, in doses of fifteen grains of the former and twenty grains of the latter once in two or three hours, as required. Under this treatment the cases progress very favorably.

The treatment of phthisis consists of the administration of cod-liver oil, whisky, anodyne cough mixture, with some form of opium at night, if required; special diet, consisting of anything which suits the patient's fancy, is allowed.

Among some of the house mixtures are —

BUCKLEY PILL.

℞ Sodæ bicarb.,
Rhei rad. pulv., āā gr. ij
Ipecac. pulv., gr. ¼. M.
Ft. pil. No. j.
Sig.—One t. i. d.

℞. Ext. conii, gr. iss
Pulv. ipecac., gr. ½
Morphiæ sulph., gr. ⅛. M.
Ft. pil. No. j.
One at night.

PILL SALUTUS.

℞. Pulv. aloes, gr. x
Ext. hyoscyami, gr. x
Ext. nucis vom., gr. ijss
Ol. anisi, gtt. v. M.
Ft. pil. No. x.
Sig.—One at night.

COUGH MIXTURE, NO. 1.

℞. Ammon. carb., gr. viij
Tr. scillæ, ℥ ij
Syr. tolutan,
Tr. opii camph., āā ℥ iv
Decoc. senegæ, ℥ iij. M.
Sig.—Teaspoonful.

COUGH MIXTURE, NO. 2.

℞ Syr. pruni virg., ℥ j
Sol. morphiæ mag., ℥ j
Acid hydrocy. dil., gtt. viij
Aquæ, ℥ iij. M.
Sig.—Teaspoonful.

The beds used in the hospital are manufactured by the Hartford Woven Wire Mattress Company, and have been in use in the institution nine years, and give perfect satisfaction. In a sanitary point of view they must be used without a mattress of any kind; two double blankets, folded and placed over the woven wire, make a perfect hospital bed; each patient, on entering, is given a clean bed.

The water bed of Neal Arnott is in constant use in our wards. It consists of a water-tight galvanized iron tank, six feet long, three feet wide, and one foot deep, placed within the railings of a bedstead frame; over this is placed a rubber sheet of the widest dimensions, or large enough to make a lining for the tank when empty. The edges of this rubber sheet are fastened, in a water-tight manner, to a strip of wood which surrounds the upper border of the tank. The tank is then filled with water, to a certain depth, according to the weight of the patient; two double blankets placed on the rubber sheet, with usual bed clothing, and the bed is ready for the patient. Patients helpless, or with bad bedsores, etc., are rendered perfectly comfortable on this bed. The entire cost of the bed is about forty dollars.

Case 1.—October 31st. H. E.; residence Hartford; Swede; domestic; age 17; single. Diagnosis, pregnancy. Patient says she has had good health while carrying her child, which is her first. Patient is able to be about the ward; limbs swollen a trifle; urine normal, on examination by the usual method.

November 24th. Patient was delivered of a male child. Position and presentation natural. The child did not breathe when born, and the color was very dark. Artificial respiration was employed, hot and cold water, and finally the mouth was applied to the child's mouth and air blown in. The child never breathed well, but survived thirty hours. The labor was rather protracted, and quite a severe one. The pains came on about ten o'clock in the evening. The child was born about twelve o'clock the following day, the first stage having lasted about nine hours, the second about five. The patient suffered considerably during the labor, and was quite exhausted at its termination. The circumstances of the case were peculiar, and seemed to have produced their effect on the patient. She was unable to get refreshing sleep, but was awake at all hours of the night. It was noticed that she was very talkative, and wanted to tell over her trouble to all around her. This tendency to talk became more and more marked, and finally became constant. Aside from the mental anxiety caused by her unfortunate condition, no cause could be assigned for her aberration of mind. The urine was examined at different times, chemically and with the glass, and nothing abnormal was found. There was no complaint of abdominal tenderness, except what is usual for the first few days. Her delirium was very curious; she recognized all around her, even those whom she had not seen for some time. She remembered events as they transpired each day, and also recalled those which happened before her sickness. She noticed all the bells about the house, and their varied calls, for doctor, etc. She answered questions intelligently, and addressed those by name who entered her room. Still, when left to herself, she would talk constantly, the most absurd nonsense, and seemed to have no idea that she was acting foolishly. After a week or ten days her tongue became very dry and red, and sordes collected on her teeth. Her bowels required cathartics and enemata to move them, and except two occasions, just before her death, did not move unless aided in this way. The delirium was always strong and active in character. She would get out of bed if not constantly watched. At times she became violent, tearing her bedclothes, etc., and when, on December 26th, she was allowed to dress and move about her room, she destroyed the furniture and her clothing. She grew worse constantly, and required restraint.

The treatment was varied. Stimulants were used freely at first; afterward full doses of cinchonidia sulph., potass. bromide and chloral hydrate were tried freely, then full doses of morphia sulph. Each had about the same effect and were attended with equally poor results.

January 2d.—Patient was very noisy and restless. About two A.M. the night nurse noticed that she was quiet, and suspecting something wrong went into her room. Patient was lying on her back, breathing puffy, and appearance described as similar to one coming out of an epileptic fit. Hypodermic injection of brandy was given freely and the patient rallied and was very comfortable during the day, and rational; at night a similar attack occurred and she never recovered, dying on the morning of the 3d.

Post-mortem.—The cranium was opened and the superficial veins were found engorged with blood. The brain substance was natural; brain large; heart and lungs normal; both kidneys were congested, the right one enlarged; in the pelvis was found what resembled pus in appearance. The omentum, intestines, bladder, uterus,

rectum, and, in fact, all the organs in the lower part of the abdominal cavity, were firmly glued together by old organized lymph, the bands in some places being quite large and firm. The cavity and substance of the uterus were normal.

Case 2.—Rochte S.; residence, Hartford; nativity, Italy; age, four years. Diagnosis, vesical calculi. This little patient was admitted to the hospital for symptoms indicating vesical calculi. The parents had noticed trouble with the passage of his urine for a considerable time; they first noticed it about a year ago. At the time of admission he was in very good condition constitutionally, but with a great amount of irritation about the bladder. Pulling the end of the penis was observed, and calculus suspected. The next day after admission the patient was etherized, and upon the passage of a sound unmistakable evidences of stone presented themselves, and it was decided to operate by lithotomy. Accordingly, on the 15th the Staff were notified, and the patient was etherized, the staff introduced and held, and the operation commenced by Dr. Wainwright, all present having confirmed the diagnosis. The median operation was chosen by Dr. W., as best fitted for this case; a small opening was made through the tissues to the urethra, and an opening was then made in the latter. On introducing the finger the stone was plainly felt, and the forceps were introduced. Some little difficulty was experienced, from the size of the stone, but it was soon extracted, and found to exceed the size which the exploration had led them to believe. Upon again introducing the finger a second stone was discovered, and upon removal was found to be larger than the first. The bladder was then washed out, and the patient given one-fortieth of a grain of morphia sulph., hypodermically. He was quiet, and had a very quiet night, having some looseness of the bowels. Five drops of laudanum was ordered; afterward he had one-fortieth of a grain of morphia, every four hours. On the fourth day after the operation he passed a little urine by the urethra, but this soon stopped, and the urine passed through the wound, and continued so until about the twelfth day; then it was noticed to pass through the natural passage, that is, the urethra. From this day the wound rapidly healed, and in about fourteen days from the date of the operation the cut was entirely healed. The morphia was only given about a week. There was very little inflammation, and the patient has been much more comfortable since the operation. The stones were not subjected to a chemical examination, but from the external appearance of one it was supposed to be phosphate, the other, probably, mixed. Up to the sixteenth day the patient was kept in bed. The larger stone weighed 172 grains, the other 110 grains. Patient was discharged, cured, December 6th, 1879.

Antiseptic surgery has been practiced in the hospital with marked success. All the details dictated by Lister have been carried out in its use.

The following case may be of some interest: John D.; a native of Sweden; age, forty-one; occupation, quarryman. About a week before his entrance into the hospital the patient received a compound fracture of the internal malleolus, and a simple fracture of the external, caused by a fall. The leg had been put up by a "Dr. Sweet," a "natural bone setter," three stitches being taken in the wound. On admission the wound was in a sloughy condition, but it was thought possible to save the leg; but, after using all the means suggested by a consultation it was found necessary to amputate, the sloughy condition having extended so far up the limb that the only choice was between death from septicæmia or amputation. In order to get above the septic matter the surgeon was obliged to amputate at the middle third of the thigh. The operation was done antiseptically. The chances seemed greatly against the patient, but he rallied well from the operation. The stump was dressed afterward, antiseptically, and no bad symptoms presented themselves. The patient continued to improve, and was discharged November 26th, five weeks from the date of the operation, the wound having entirely healed. The rapid recovery seems fairly attributable to the antiseptic surgery. This is only one of many cases which seem to uphold Lister's method.

Editorial Department.

Periscope.

Chloride of Calcium in the Treatment of Phthisis.

James Sawyer, M.D., M.R.C.P, says, in a communication to the *British Medical Journal*, June 5, 1880—

Have we a remedy for phthisis? We now know that the term chronic pulmonary phthisis includes a variety of pathological conditions and a variety of textural lesions in the lungs which have long been recognized as distinct, which recent research has done much to unravel, and about which we may still expect to learn more. We know the differing clinical and pathological courses of tubercular phthisis, unresolved lobar pneumonia, chronic catarrhal lobular pneumonia, and pulmonary scirrhosis. All these are included in the generic name phthisis. When I say have we a remedy for phthisis? I mean have we a remedy for this allied group of conditions, due to varying pathological changes, but marked in common by progressive wasting of the body, by progressing asthenia, by progressing diminution of respiratory capacity, and by fever of a hectic type. Every case of phthisis requires special study, and can be treated by no rule-of-thumb practice because it is phthisis. In one

case anæmia is prominent and calls for iron, perhaps for arsenic; in another, continued but small hæmoptysis calls for ergot or hamamelis; in another, a racking and frequent cough calls for opium, morphia, or codeia; in another, dyspepsia calls for alkalies, or acids, or bitters, or pepsine; in another, nervous unrest calls for bromides; in another, laryngeal troubles call for special local medication; in another, we have to aim at controlling excessive sweating or checking an exhausting diarrhœa. Apart from these and other particulars, I suppose we are all agreed that cod-liver oil, given alone, or variously combined with other agents which tend to promote its assimilation, as with ether, as suggested by Dr. Foster, stands at the head of remedies calculated to promote the general nutrition of the phthisical. Have we any other general remedy? For a long time I trusted to syrup of the iodide of iron. This I gave up for a mixture of hypophosphites and iron—five grains of hypophosphite of lime, ten grains of hypophosphite of soda, and fifteen minims of syrup of the phosphate of iron, for a dose. This is a good combination, and I still use it. But chloride of calcium is my favorite drug. I have used it for some years in hospital and private practice, and I believe with great advantage. Perhaps you will say, Do you give it alone? I do not. I give it with cod liver oil, or with cod-liver oil emulsion, or with morphia, or with ergot; but my general impression is, *quantum valeat*, that I get better results with chloride of calcium with these combinations than I do with anything else in the same combinations. My attention was called to the value of chloride of calcium in phthisis by a paper in one of our medical journals, wherein it was stated that the drug was much used by the late Dr. Warburton Begbie. Scarcely mentioned, if noticed at all, in books on drugs, chloride of calcium has an old repute for the cure of strumous glandular swellings. In phthisis I give ten grains, dissolved in a drachm of water and mixed with a drachm of glycerine, in a wineglassful of milk, twice daily, immediately after meals. I think it tends to check night-sweats, to cause increase of weight, and to dry up pulmonary lesions. Of course I do not maintain it does these things in all cases. What I have stated are general conclusions, open, I am aware, to objection, on the ground of their insufficient logical basis, but conclusions which have been and are for me grounds of therapeutic conduct. In prescribing chloride of calcium, we must be careful to write the name of the drug distinctly and in full, in order to avoid an error from which one of my patients suffered, namely, the substitution of "chloride of lime."

Metallo-therapy.

Dr. L. H. Petit gives, in the *Bulletin General de Thérapeutique*, May 15th, 1880, a detailed account of seven cases, chiefly of hysterical anæsthesia and hemianæsthesia, treated by the internal and external employment of metals. He also mentions a case of paraplegia in a young and nervous woman, evidently of hysterical origin, in which the metallic treatment totally failed, but in which, also, the author considers it was not properly carried out. Gold was first applied without effect, and copper was then substituted for it, with the unexpected result of causing such intense sciatic pain that it was necessarily abandoned. In regard to this case, Dr. Petit remarks that, although the patient was insensible to gold, she was not necessarily so to silver, platinum, or zinc, which, however, were never tried; that this metal should have been applied in the form of "bracelets' instead of large plates; and, finally, that magnets and continuous currents, which have often succeeded when other means have failed, should have been resorted to. His sixth case is a good example of the poly-metalism of certain individuals. The patient was aged seventeen, and suffered from double hysterical amblyopia, dyschromatopsy, insufficiency of the internal recti, analgesia, and anæsthesia of the whole right side of the body, and, later on, of the left. Treatment by chloride of gold internally, and discs of metallic gold externally, for three months, resulted in the recovery of the color sense, while, on the contrary, the visual acuity, without any ophthalmoscopic lesion, continued to decrease. Silver was now employed, together with the gold, and within fifteen days from the application of the former metal on the forehead sensibility returned to the right side, and all the eye and ear symptoms disappeared. Later on, all symptoms whatever of hysteria ceased, and recovery was eventually complete and permanent. Dr. Petit also cites a case of writer's cramp treated by gold internally and externally, magnets and electricity having previously failed. Four to five drops of a solution of 1 in 20 of chloride of gold were administered, and discs of the same metal were worn night and day for a month. At the end of this period the patient was so far improved as to be able to hold his pen for twelve hours daily. Other interesting cases are also given in the same periodical for March 30th and April 15th. In one, apparently a unique example of paraplegia was cured by metallo-therapy, without transference; in another, a very obstinate tendency to contraction was overcome by the use of magnets.

Sub-phrenic Pyopneumothorax and Abscesses.

Under the name of sub-phrenic pyopneumothorax, Dr. E. Leyden describes, in the *Zeitschrift für Klinische Medicin*, Band 1, cavities full of air and pus, found beneath the diaphragm, and extending more or less into the thoracic cavity, so as to produce physical signs very closely resembling those of genuine pyopneumothorax. These abscesses may be formed either on the right or on the left side. The mechanism of the origin of these air-containing suppurating cavities is closely connected with a history of perforative peritonitis; they are most frequently the result of perforating ulcers of the stomach or duodenum. Their tendency, when left to themselves is, almost without exception, toward death. It appears that they most frequently perforate the lung; but they may discharge in other ways. Perforation of the stomach or the transverse colon may end favorably. Dr. Leyden's observations have shown him that the diagnosis of sub-phrenic

pyopneumothorax may generally be made with certainty; and the diagnosis is of great practical importance, as life may be saved by operation. The following are, according to Leyden, the diagnostic characters of sub-phrenic pyopneumothorax:—1. The development of the disease is preceded by symptoms of general (perforative) peritonitis or discharges of pus by the bowel. 2. An exudation takes place in the lower part of the thorax (right or left) with symptoms of inflammation; cough and expectoration being absent, at least for a long time. 3. There are distinct symptoms of pyopneumothorax in the lower part of the chest, viz., complete resonance on percussion as far as the border of the ribs, and dullness in the lower and posterior part; in this region the respiratory murmur and vocal fremitus are absent, and metallic tinkling is heard on simultaneous auscultation and percussion; the succussion sound is distinct. 4. At the same time examination shows that the lung above is unaffected, and that it descends during deep inspiration. Beneath the clavicle there is vesicular respiratory murmur, and the vocal fremitus reaches as far down as the third or fourth rib. On deeper inspiration, however, the normal respiratory murmur is heard as low down as the fourth or fifth rib; while at the same time all respiratory sound is sharply cut off below this limit. 5. The dullness on percussion, corresponding to the exudation, is rapidly and distinctly altered by changes in the position of the body, but the change is limited to the lower part of the chest (*i.e.*, beneath the diaphragm). 6. The signs of increased pressure in the pleural cavity are either absent or very indistinct. The corresponding half of the thorax is scarcely distended, the heart is but little pushed aside. On the other hand, the liver reaches as low down as the umbilicus, or even lower. 7. In the further progress of the case, any doubt that may have existed as to the diagnosis may be removed by the sudden and abundant expectoration of ichorous pus, indicating perforation into the air passages. 8. Finally, the diagnosis may be confirmed by manometric examination of the pleura. Pfuhl had already remarked that, in puncture, combined with the use of the manometer, when the cannula is in a cavity beneath the diaphragm, inspiration is attended with an increase, and expiration with a diminution of pressure: being the reverse of what occurs when the cannula lies in the pleura.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——We have just received the first "Annual Announcement of the St. Paul Medical College," medical department of Hamline University, Minnesota, and we are glad to see that the course of study in this new institution has been extended to four years, the lecture term opening on the first Tuesday in October, and closing on the last Saturday in May.

——A pamphlet containing a report of "Three Cases of Syphilitic Muscular Contraction," extracted from the *American Journal of the Medical Sciences*, for April, 1880, has been sent us by the author, Arthur Van Harlingen, M.D., chief of the Skin Clinic, Hospital of the University of Pennsylvania, and also a reprint from the *Archives of Dermatology*, for April, 1880, containing a report of a "Case of Chronic Inflammatory Tuberculo-vesicular Skin Disease," by the same author.

——"Supply and Demand in its Relation to the Growth, Development and Health of the Human Body," is the title of an address delivered before the Coles County Academy of Medicine and Surgery, at Mattoon, Illinois, March 9, 1880, by V. R. Bridges, M.D., which now comes to us in pamphlet form.

BOOK NOTICES.

The Practitioner's Reference Book. By Richard J. Dunglison, A.M., M.D., Editor of Dunglison's "Medical Dictionary," Secretary of the American Academy of Medicine, etc., etc. Second edition, revised and enlarged. Philadelphia, Lindsay and Blakiston, 1880. Cloth, 8vo, pp. 476. Price $3.50.

In preparing the second edition of this work the author has added materially to its usefulness by the introduction of a large amount of new matter. Among the most important additions made may be mentioned the chapter on "How to Write Metric Prescriptions;" directions as to the Use of the Hypodermic Syringe in diseases in which it is applicable; how to use a Galvanic Battery in Medicine and Surgery; how to apply Trusses to Herniæ; how to use the Clinical Thermometer; how to prepare Stained Sections of Animal Tissues; reference tables of size, weight, and specific gravity of all the organs, etc., of the body; celebrated prescriptions or remedies; Therapeutics of the Bowel Affections of Children; diagnostic tables of the principal fevers; diagnostic tables of Acute Pulmonary Diseases; diagnostic tables of Diseases of the Larynx and Naso-pharynx; diagnostic syllabus of Tumors of the Groin; ready reference table of antidotes on a new plan; rules of medical etiquette, etc., etc. The size of the present volume has thus been increased by 135 pages, without, however, affecting the price of the book. A review of the first edition will be found on page 135, August 18th, 1877, to which our readers are referred for further information. The book is handsomely gotten up.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE MEDICAL ASPECTS OF EDUCATION.

III.—Scholastic Education.

The points we wish to bring out in reference to school life are but variations of what we said under "Household Education." The question there was, *Quis custodiat ipsos custodes?* Who shall teach the teachers? Without their intelligent aid it will be vain to expect that the sanitation of school life will be observed. They cannot give such aid, because they neither know its necessity nor its principles. Here lies the duty of the medical profession, and it is an urgent one.

One example will suffice. In a report published not long since, on the public schools of Wisconsin, by Dr. J. T. Reeve, of the State Board of Health, he states that it would seem that the physiological laws that govern the growth and action of the human system should be thoroughly comprehended, especially by teachers and school officers, and that the study of physiology and hygiene should form an essential part of the course pursued in all our public schools; yet as the result of an investigation, made by direction of the Wisconsin State Board of Health, into the extent to which these studies actually are pursued in those institutions, he found that very seldom is any place systematically provided for either in the school curriculum, and that in 5197 out of a total of 5361 school districts in the State (exclusive of independent cities), no text books upon these subjects were in use. The inquiry further revealed the fact that no knowledge of these branches or of the structure of the human body is required as a necessary antecedent to enable a teacher to obtain the third-grade certificate, which is held by seven-eighths of all the instructors in the public schools of Wisconsin.

That this ignoring of a study which is certainly among the most useful of all studies is not in accordance with the dictates of wisdom and prudence, will, we think, be evident to one who attentively examines the sanitary condition of the public schools and those who attend them, in almost any State in the Union. Teachers should not be held qualified for their position unless they know the principles of sanitary science and personal hygiene. They should be required to observe them in their avocation, and explain them to their pupils.

To this should be added a general knowledge of the functions of the body, of the outlines of physiology. This is, in fact, essential to the proper understanding of hygienic laws. It is well remarked by a recent advocate of the more general study of physiology that the more men become acquainted with the structure and functions of their own organism, the more they will fear, shun, and despise ignorant pretenders in the healing art; the more they will hesitate to try upon the body the effects of medicines and remedies with which they have no acquaintance whatever, and that we have here, therefore, the best means of protecting both the public and the profession against quackery. Furthermore, as the engineer, in order to work and preserve his engine, must know something about its construction and actions, so it seems essential that man, in order to make the best use of his body and

preserve it, must know something about its structure and functions. To be sure, men might, if they would, perhaps carry out blindly the laws of health without a knowledge of physiology; but most of us in this age want to know the "why and the wherefore" of things. It is not usually enough to know that health will follow the carrying out of such laws; most of us want to know why and how health follows such a course. Many children even desire to know, and it is desirable they should know, in what way the air is fouled by respiration, and how impurities in the air get into the blood; why it is best to eat slowly of digestible food, and to masticate it thoroughly; and why it is bad to take violent exercise just before or after a full meal. To derive the greatest amount of benefit from exercise, it appears necessary to know something about the construction and action of the muscles, and the effects of exercise upon the circulation and respiration. With a view to perfect cleanliness of body, it is desirable for every one to know something about the structure and functions of the skin. Finally, as a part of even an ordinary education, it seems just as necessary or desirable for one to know something about the human body—the "noblest work of God"—as about the steam engine, the printing-press, or the electric telegraph.

The questions of school architecture, the hours of study, the protection of the eyes, the use of gymnastics and athletic sports, playgrounds, etc., all turn on this fundamental one of health; and here it is that the active intervention of the physician in this vast subject of education becomes imperative, if education is to do the most it can for the race, that is, to exert upon it an organic and permanent beneficial effect.

Notes and Comments.

Therapeutical Notes.

REMEDY FOR CORNS.

Mr. Gezow, an apothecary of Russia, recommends the following in the *Pharmaceutische Zeitung* as a "sure" remedy for corns, stating that it proves effective within a short time and without causing any pain: Salicylic acid, 30 parts; extract of cannabis indica, 5 parts; collodion, 240 parts. To be applied by means of a camel-hair pencil.

FORMULA FOR SORE NIPPLES.

Dr. Howell recommends the following in the *Canada Medical Record*:—

℞.	Tannin,	ʒj	
	Sub-nit. bismuth,	ʒij	
	Vaseline,	℥j.	M.

Sig.—To be applied constantly when the child is not nursing.

Osteoplastic Resection of the Elbow Joint.

Under this name, Dr. O. Völker describes, in the *Deütsche Zeitschrift für Chirurgie*, Band 12, a temporary resection of the olecranon, the object of which is to make the cavity of the elbow joint freely accessible. He first performed the operation in a case of old imperfect lateral displacement of the left elbow joint, in a boy thirteen years old. The head of the radius projected on the radial side, and the inner condyle of the humerus on the ulnar side. The joint was almost stiff, and sensation and motion were considerably impaired in the region of the ulnar nerve. Before operating, Dr. Völker made an attempt at reduction, but without success. Two parallel incisions were made along the sides of the olecranon, and were joined below by a transverse incision at the level of the articulating surface of the radius; the bone was then sawn through. The adhesions of the ends of the joint to one another were then divided, partly by a knife, partly by a blunt instrument, and the fore-arm could now be replaced. Two splinters of bone lying close to the ulnar nerve, and one which had become adherent to the supratrochlear fossa, were removed; the olecranon was then brought into its normal position. The articulating surface of the head of the radius, which projected a little, required removal. The wound was treated antiseptically, and healed without any other accident than the sloughing of a small piece of skin. Four weeks after the operation passive movements were commenced; the joint could soon be bent beyond a right angle, and almost completely extended, by the voluntary action of the patient. Pronation and supination were quite free; and the disturbances of the ulnar nerve had altogether disappeared. The result of the operation was thus perfect restoration of the form and function of the joint. Dr. Völker believes that osteoplastic resection of the elbow is indicated in cases of irreducible dislocation (recent and old), of foreign bodies introduced into

the joint, of broken-off pieces of articular cartilage and other substances lying free in the joint. He says that it is most important to restore the bony union of the olecranon with the ulna. Antiseptic treatment of the wound is indispensable; and cases in which the olecranon is not certainly intact, as well as most cases of caries, are not fitted for the operation.

TheBlood in Febrile States.

M. Hayem, says the *Lancet*, who has added so much to our knowledge of various morbid states of the blood, has lately published some observations on the minute alterations in the mode of formation of the coagulum in various febrile states. When the blood is spread out in a thin layer under the microscope, the corpuscles are seen to assume a special arrangement. The irregular spaces which the rouleaux leave are larger and less numerous than under normal conditions. If, after coagulation, an attempt is made to separate the elements, it is found that the corpuscles are united by extremely fine filaments of fibrine, which cause them to assume very irregular shapes; they present, also, an abnormal viscosity when compressed by the surrounding fibrine. Other changes which the blood presents cannot be, with certainty, ascribed to the inflammatory processes. Even when the pyrexia is high there is no alteration in the dimensions of the red corpuscles. The increase in the number of leucocytes affects equally all forms of pale corpuscles, their mutual proportion being about the same as in normal blood. Nor do these present any structural alterations: their amœboid movements are the same as in health, except that they are somewhat interfered with by the filaments of fibrine which adhere to them. Many "hæmatoblasts" occupy the empty spaces, and, like the red corpuscles, they become more viscous and adherent one to another, and hence quickly form masses, notably larger than those seen in normal blood. Very soon a reticulum appears, considerably denser than in other circumstances, the constituent filaments being thicker and closer than those of normal blood. During this formation the hæmatoblasts have fused together into little blocks of waxy aspect, to which large numbers of fibrils are attached, giving them a characteristic appearance of balls of spines. The excess of fibrine in the blood gives rise to another appearance if the blood is diluted with the liquid used in the ordinary numeration of the corpuscles; minute solid particles become visible to the naked eye in the mixture, an appearance never seen with normal blood. These particles are composed of hæmatoblasts, surrounded by a finely granular or fibrillar substance, to which many leucocytes and red corpuscles adhere. These changes in the blood may be found, although in a less marked degree, in cases of chronic as well as in acute inflammation.

Influence of Electricity on Bacteria.

According to the *Medical Press and Circular*, June 9th, 1880, some new experiments with regard to the influence of electricity on bacteria have been published by Professor Cohn, who adopted the method of sowing with bacteria a sterilized mineral nutritive solution, subjecting them to electric currents, and noting the results. A Marie-Davy flask element he finds to exert (according to strength of current) either no influence on the increase of bacteria, or merely a retardative influence. On the other hand, the current from two powerful elements sterilized the nutritive solution completely at the positive pole in twelve to twenty-four hours, so that afterward the bacteria introduced did not increase. At the negative pole the action was weaker, the liquid not completely sterilized. At neither of the poles were the bacteria killed, and when brought into another nutritive liquid they developed normally; on the other hand, yeast cells, and mycelium fungus brought into the liquid that was sterile for bacteria, increased plentifully at the positive pole. A battery of five strong elements killed the bacteria distributed in the liquid within twenty-four hours, and sterilized the liquid of both poles.

Japanese Inundation Fever.

Under this name (*Japanische Fluss-oder Ueberschwemmungsfieber*), E. Baelz and Kawakami describe, in Virchow's *Archiv*, Band 78, a disease hitherto unknown to Europeans, which breaks out every year, in July and August, in parts that have been inundated during the spring. It is an acute, non-contagious disease, with a typical febrile course, commencing with limited necrosis of the skin, and leading to swelling of the lymphatic glands and a cutaneous eruption. There are no special premonitory symptoms. The onset of the disease takes place generally after six days' residence in the infected locality, with rigors, headache, loss of appetite, and great feeling of debility. The lymphatic glands soon become painful, and the skin in their vicinity rapidly becomes necrosed. This, with the resulting ulcer, is the specific and characteristic sign of the inundation fever, and is never absent.

The patients are abnormally sensitive to draughts of air and to the contact of water. The temperature gradually rises, until at the end of the first week it reaches 104° Fahr.; it then remains at this height for eight days, and gradually returns to the normal in the course of the third week. The frequency of the pulse is slightly increased during the fever. A sudden increase in the frequency of the pulse in the third week, when the temperature is normal, is a warning of severe symptoms. On some part of the skin there is formed a dry scab, which, in being thrown off, leaves a crateriform ulcer. The neighboring lymphatic glands swell and become tender to the touch. Catarrh of the conjunctiva is always present. On the fourth or sixth day there generally appears a papular, non-suppurating eruption, first on the face, then on other parts of the body. The exanthem indicates that the disease has reached its acme, and lasts from four to six days; it is attended with continued high fever. At the end of the second week the fever begins to remit, and convalescence rapidly sets in. The mortality is about fifteen per cent. The authors regard the disease as of miasmatic origin. Salicylate of sodium in small doses appears to be useful, while quinine has no effect. In order to prevent the development of the poison, the authors recommend the cultivation in the infected districts of the *Paulownia imperialis*, which possesses many advantages over the eucalyptus.

Correspondence.

"Conservative Midwifery."

Ed. Med. and Surg. Reporter:—

I have read with great pleasure the able article of George Hamilton, M.D., entitled "Conservative Midwifery." He refers to a paper in the *Pacific Medical and Surgical Journal*, by Henry Gibbons, Sr., M.D., "A Protest Against Meddlesome Midwifery." In winding up, he expresses a "hope that other authors, lecturers, and practitioners may come to his support in this effort in behalf of a more conservative practice than now prevails." "When duty calls 'tis ours to obey." From a conviction of duty in behalf of poor woman, I venture, in this off-hand communication, to fully endorse all that Dr. Hamilton says in support of his position, and wish that I could read Dr. Gibbons' paper also, for I have no doubt of giving it my full approval, if I should. In my reading of opinions in favor of the frequent use of the forceps, and reports of experience in the same, I have not yet been convinced that artificial means should be resorted to to facilitate labor, when, to use a homespun expression, "The mother was getting along very well, and everything going on naturally."

I am well acquainted with a great many physicians in this part of Louisiana, and quite a number in New Orleans and from several different sections of the State, having been a practitioner here for nearly twenty-eight years. The intelligence and success of the Louisiana physicians will compare favorably with those of any part of the country; and so far as my acquaintance with their practice is concerned, I believe there has been but little necessity of instrumental delivery. In fact, a great deal of the obstetrical practice in many localities is in the hands of negro midwives, who could not and would not attempt to use forceps, but in lingering cases promptly send for a doctor; and still the cases get along well. The most delicate, as Dr. Hamilton says, get along the easiest.

My father practiced in New York and Ohio for nearly sixty years, and wherever he lived he always had a large obstetrical practice; his preceptor and father-in-law, a prominent physician in New York for I do not know how long, taught him, as he taught me, that "meddlesome midwifery could not be too much condemned." I only mention this, as Dr. Hamilton refers to Dr. Gibbons, and his long experience, that in many years of extensive practice, although the use of forceps was well known, artificial interference was deemed necessary only in exceptional cases.

I think Playfair, in his edition of Midwifery, of 1880, in describing forceps, page 465, makes a very sensible remark: "They may be described as a pair of artificial hands, by which the fœtal head may be grasped and drawn through the maternal passages by a *vis a fronte*, when the *vis a tergo* is deficient."

Yes, "when the *vis a tergo* is deficient." Of that, however, I think the physician should be able to judge, and well satisfied, before he makes application of his "artificial hands," and thereby causes to his patient unnecessary alarm, and incurs the risk of injury, perhaps irreparable, to one or both, mother and child.

Of course, with many people, all the display and extra manipulations, if all turns out right, has its effect in advancing his interests; and occasionally a poor fellow steps from the ditch of poverty up into the road to wealth, by accidentally giving prompt relief to a suffering patient; but this does not excuse the teaching of that which is likely to lead many to venture a practice resulting in harm. Conservative versus meddlesome midwifery should still continue to be thoroughly impressed upon the mind of the student by authors and teachers.

O. P. Langworthy, M.D.

Clinton, La., July 2, 1880.

News and Miscellany.

The Manufacture of Iodine in South America.

According to the London *Medical Record*, June 15th, 1880, the province of Tarapaca, in Peru, now contains eight manufactories in full work, which produce annually 140,000 kilograms of iodine. Three other manufactories are in course of construction, and the production of iodine in 1879 has attained from 150,000 to 200,-

000 kilograms. Different processes are used to extract iodine from the waters of saltpetre. The first process consists in precipitating the iodine with a determined quantity of sulphate of sodium, and the iodine is afterward extracted, after having been washed, filtered, etc. The second method consists in adding to the water either sulphate or bisulphate of sodium, until the iodine is transformed into iodohydric acid, which is precipitated by the aid of a solution of chloride of copper. In the first method the crystallization process is used, then the mother waters are distilled with a quantity of bisulphate of sodium equivalent to the density of the iodine.

Extraordinary Fecundity.

According to a paragraph in *La France Médicale*, a woman, whose name and address are given, was several months pregnant when she was seized with colicky pains. Attributing them to ordinary causes, she went into her vineyard, and was profoundly astonished to discover presently that she had been confined. Dr. Watering, of Maregnac, was called to her, and found that she had given birth to eight children, perfectly formed. They were enclosed in a sac, and had apparently perished from mutual pressure during their growth. The mother did well.

Death of a Physician.

A special dispatch to the Cincinnati *Gazette* says Dr. R. M. Hills, of Covington, Ind., committed suicide on the 5th instant, by shooting. He was a leading physician in that county for the last twenty-five years, and was wealthy. Ill-health and consequent despondency are supposed to have been the causes that led to the act.

OBITUARY NOTICES.

—Dr. Manly Emanuel died on the 2d inst., at his residence, No. 1324 Green street, at the age of 86 years. He was born in Devonport, England, and pursued his medical studies at St. George's Hospital, London, at which place he also graduated in 1816. He then settled there, but removed to this country in 1836, and took up his abode at Linwood, Delaware county, where he resided about thirty years. He removed to this city about ten years ago, where he remained up to the time of his death. He was a member of the American Medical Association and a Fellow of the Royal College of Surgeons, of London. He was President of the Delaware County Medical Society, a position which he filled about sixteen years, and was President of the Board of School Directors in that place. He at one time held the position of United States Examining Surgeon for pensioners, and was a justice of the peace for Delaware county during his residence in that section of the country.

—Alfred Swaine Taylor, M.D., F.R.S., the well-known medical jurist and toxicologist, died at his residence in St. James' Terrace, Regent's Park, on the 27th of May last. He was born in Northfleet in 1806, was educated at a private school, and studied medicine and surgery, under Sir Astley Cooper and Mr. J. H. Green, at the Hospitals of Guy's and St. Thomas'. After attending the medical schools of France, Germany, and Italy, he took the M.R.C.S. Eng., in 1830, and the M.D. St. And., in 1852, and in the following year was elected to the Fellowship of the London College of Physicians. Dr. Taylor was the first occupant of the chair of Medical Jurisprudence at Guy's Hospital, an appointment which he held till within a short time of his death. It was in connection with this subject that his name was known all over the world, his works on "Poisons," "Medical Jurisprudence," and "Chemistry" being justly esteemed as standard treatises. As an authority in medico-legal questions his loss will be keenly felt by a large section of the community, while as a trusted physician and friend the place he has left vacant will not easily be filled.

QUERIES AND REPLIES.

Dr. Webb J. Kelly, of Galion, Ohio, writes, in reply to the query of Dr. J. M. B., of Pa.:—

Use infusion belladonna until the physiological effects are noticed. Give the patient all the milk he will drink. Have often found that infusion of tobacco will effect a cure when everything else has failed.

Dr. D. P. Boyer, of E. Palestine, recommends—

℞. Ung. hydr., ʒj.
Pulv. camph., ʒj. M.

stating that he has used it for many years, with invariable success.

Drs. T. and B., of N. Y., think that a strong solution of nitrate of silver, applied over the whole organ twice daily, until the patient objects on account of pain, will prove effectual.

Dr. J. M. Keller, of Hot Springs, Ark., thinks that speedy relief will be obtained by injecting the scrotum, night and morning, with one-fourth grain of morphia, and by getting an ordinary toy balloon and stretching it over the testicle, taking the precaution to see that the neck does not bind too tightly around the cord and vessels. It is unnecessary to remove it to inject the morphia, as the needle easily penetrates. Blistering, rubefacients, poultices, hot and cold bags, should all be discarded. They are, at best, only excitants.

MARRIAGES.

BOARDMAN—GRISWOLD.—In Morrisville, Vt., June 3d, by Rev. W. A. Bushee, Dr. H. S. Boardman, of Woodstock, and May Griswold, of Morrisville.

BROWN—LESTER.—At the residence of the bride's parents, on the evening of June 22d, by the Rev. Albert B. Simpson, Dr. Charles H. Brown and Annie M., daughter of Andrew Lester, Esq., all of New York.

DEATHS.

MARCY.—In Cape May City, New Jersey, June 30th, Mrs. Thankful B., wife of Dr. Samuel S. Marcy, in the 80th year of her age.

ROGERS.—June 25th, at 3 A.M., at his late residence, near Covington, Ky., Dr. M. Rogers, in the 84th year of his age.

STEBBINS.—At Geneva, N. Y., on Wednesday, June 30th, Francis Matilda, wife of James H. Stebbins, M.D., and youngest daughter of the late Jacob and Frances Lansing Sutherland.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1221.] PHILADELPHIA, JULY 24, 1880. [Vol. XLIII.—No. 4.

Original Department.

Communications.

CASES WITH ACCIDENTAL AND RARE COMPLICATIONS.

BY HUGO ENGEL, A.M., M.D.,

Fellow of the American Academy of Medicine, Physician to St. Mary's Hospital, etc., etc.

Bronchitis—Sudden Bursting of an Old Abscess into the Peritoneal Cavity—Acute Gastritis and Tubercular Meningitis—Simple Basilar Meningitis.

There are certain cases in every physician's practice which should invariably be put on record; cases comparatively common and inconsiderable, in which, though suddenly, an unforeseen complication arises that utterly alters our prognosis and ends the patient's life, which the original complaint did not threaten at all. Again, there are cases where a never-thought-of complication effaces the picture of the main disease and makes the diagnosis very difficult; cases where the diagnosis would be of the utmost importance on account of the prognosis. We all know how frequently the latter is most anxiously awaited. Instances like those mentioned teach us, more than any other, to be careful in our utterances, and to always and ever remember that it is safer to add—in even mild and apparently simple cases—that "if" which will leave us a loophole by which to escape ridicule, to which in such instances we would otherwise be exposed, especially among the ignorant and from too selfish colleagues. They further remind us not to be hasty in our judgment when we are requested to make a diagnosis in a case which before us had been attended by a medical confrère. The group of symptoms may have been totally different when the latter saw the case, and a mistake that our professional brother apparently made may be more to his credit than our seemingly correct diagnosis is to us.

Thoughts like these occurred to me when I looked, some days ago, over my record of cases and saw those instances again where such remarkable complications had confused and at first misled me. The more we see and read such cases the more careful we become; and it is in this animus that I intend putting on record such observations of mine as belong to the kinds just indicated.

Mrs. B., 37 years of age, mother of seven children, of healthy parentage and without any taint of the system, had for several years been occasionally attended by me for a rather severe bronchitis, a simple affair always in the beginning, but increased by the very careless patient to a rather severe form. When affected by a slight cold, and when perspiring, perhaps freely, in consequence of the action of some diaphoretic house remedy, she would suddenly, in the night, leave her bed and go barefooted into the yard, to walk there for a little time on the damp or even wet bricks, to "get cooled off somewhat." Some hours later a most active bronchitis would develop, and generally, on account of the accompanying dyspnœa, I would be sent for. A somewhat similar history I elicited almost each time. The bronchitis, though, was always far from being dangerous, and as she had the good sense to follow minutely the directions of the physician, as long as he visited her, she generally got well within about a week. But each time she, as well as her

husband, were afraid she would die, and they both always doubted for a day or two my assurance that such would be by no means the case, if (my usual addition to every favorable prognosis) nothing unforeseen should happen. I have now to remark that some time before I became physician of the family another M.D. had attended Mrs. B. for some uterine complaint, the precise nature of which I never had been able to find out. She had then suffered very much pain above and to the right of the symphysis, been very feverish, and laid up in bed for about three weeks. Leucorrhœa existed at present in a mild degree, and whenever a change of weather threatened, or near the approach of her monthly period, Mrs. B. would complain about all kinds of vague pains somewhere in her abdomen. These were never confined to any particular place, and would disappear again of themselves. She refused an examination, and a midwife delivered her about every two years. Parturition seemed always to be normal.

September 10th, 1878, I was called to see her, and found her suffering, as usual, from a rather severe catarrhal bronchitis. Again the history of repeated exposure to cold was given. Temperature, 101°, pulse 96, number of respirations 34, skin hot and dry. There were all the symptoms and physical signs of the malady mentioned. The urine contained no albumen. Pain was only felt under the sternum, and there only when coughing. I ordered her—

℞. Antimonii et potassii tart., gr. ij
Spiritus mindereri, f. ℥ iv
Tinct. veratri viridis, f. ℥ ss
Spiritus ætheris nitrosi, f. ℥ j
Syrup. simplicis, q.s.ad f. ℥ vj. M.

Sig.—f. ℥ ss quâque 2da horâ.

30 dry cups over the chest, to stay in bed and to have a mild, unirritating diet. I assured the patient and her husband that there was not the slightest danger to life, "if," etc. September 14th, the patient was so much improved that—the inflammation having subsided—I told her to omit the mixture and take the following instead:—

℞. Ammonii muriatis, f. ℥ vj
Mist. glycyrrhizæ comp. f. ℥ iv
Syrup. pruni Virginianæ, f. ℥ ij. M.
Filtra.

Sig.—℥ ij quâque 3da horâ,

and gave her besides pulv. doveri, gr. x, at night.

The next day she was still better, but complained about a little pain in the hypogastric region.

September 16th. I was sent for at nine A.M. I found her temperature, which the first day had been 101, and then became normal, now to be 105°. She suffered from severe pain in the middle of the lower part of the abdomen, and this pain was increased on the slightest pressure. She had not been able to sleep during the night. Notwithstanding that the patient told me that she often had similar pains before her menses appeared, and that she expected the latter, I had my misgivings. I now examined her sexual organs, and could detect only unusual heat of the parts, and at no place any tenderness. Percussion over and inspection of the abdomen revealed nowhere anything wrong. The patient had experienced some chilly sensations ere the high temperature set in, but no rigor. The urinary functions were normally performed; the abdomen was not swollen, there existed no fullness in the right iliac fossa, and the tenderness was diffused over the whole lower part of the abdomen. Suspending the treatment the patient was under, I ordered twelve leeches to be applied to the tender region, twenty grains of quinia and one grain of morphia to be taken at once, quiniæ sulph., gr.iij, and morph. sulphat., gr.ss, to be given ever three hours, and to notify me directly of any change toward worse that might take place. I called again near five P.M., when the patient told me that soon after the application of the leeches her menses had appeared, and that she was now and since then free from pain. All tenderness had vanished, the temperature was 100°, the bowels had moved once and the urine passed as usually. The abdomen revealed nothing wrong.

The next day, September 17th, Mrs. B. was feeling quite well, but had again not been able to sleep during the night; temperature 100°, pulse 112, soft and compressible, no pain, no tenderness, no swelling of the abdomen; the menses ran their normal course, and the cough had disappeared. I ordered the powders to be given only three times a day, and prescribed a chloral mixture, dose twenty grains, to be taken at night. Next morning at 7 A.M. I was sent for and found the patient dying. Directly after the dose of the chloral, as the husband told me, she had become restless and complained again of severe pain in the abdomen. Toward morning she had a rigor, after which high fever set in; then, suddenly, when they wanted to send for me, all pain ceased and she began to feel very comfortable. Half an hour before my arrival her countenance had changed rapidly, and it was this appearance of the hippocratic face that urged them to call the physician.

Her husband, whom I had told in the beginning, but not without my usual "if," that there was no danger to life, whom I had assured that I was reasonably certain that the patient would sleep after the chloral dose, but who had observed, instead of this effect, the setting-in of great restlessness and severe pain, followed later by all the symptoms of the fatal collapse, went to the apothecary, asked for a copy of my prescription, and put the chloral solution carefully away, evidently in the earnest conviction that I had killed his wife by the sleeping draught, and full of revenge and desire to collect all the parts and links of the chain of evidence necessary to hang me. But all this he did not communicate to me. When he, therefore, accompanied by his brother, came to me for the certificate of death (perhaps useful too, as a link) I refused the same; told him that I knew very well the foolish suspicion he had; that I was willing, any evening when I had nothing else to do than to sleep, to swallow in his presence a dose of the medicine (after having convinced myself that no other drug had been added to it); but that I had now to insist on a post-mortem examination, to prove beyond the shadow of a doubt that the patient had died of what I suspected. And then I explained to him that, according to my belief, the patient, when attended, some four or five years before, by another physician (as mentioned in the beginning of this report), had been affected with inflammation of the pelvic cellular tissue; that at that time an abscess had formed, but not been opened; that this abscess later became incapsuled; that at her last illness, when in consequence of the near approach of the menses the parts in the pelvis were more or less plethoric, inflammation, sympathetic with the bronchitis, or due to the same causes as the latter, started in the tissues dividing the abscess from the peritoneal cavity, and that at last the former burst into the latter, and so produced death. I observed on the countenance of the worthy gentlemen a somewhat incredulous expression, but did not care about their opinion then, as I felt reasonably sure that, taking all in all, something of the nature of the above must have happened, to produce the fatal end. I further requested the gentlemen to name any regular physician whom they might wish to witness the post-mortem, and this they did. The dissection was made in the most skillful manner by my friends, Drs. William A. Johnston and Jos. H. Lopez, and at my solicitation Prof. J. M. DaCosta kindly consented to give, by his presence, the affair that authority which his name necessarily carried along. Well, to be brief, the autopsy revealed exactly what I had explained before. There were traces of an old extensive inflammation; the right kidney was bound down by adhesions, and in the right iliac fossa, just below the processus vermiformis of the cæcum, the peritoneum and the pelvic cellular tissue were all found thickened and surrounding a cavity, which extended backward and was about the size of a hen's egg; it contained some gray-greenish pus, and the same fluid was found in the peritoneal cavity. The opening through which the abscess had burst was large enough to admit the little finger. The whole lower half of the peritoneum was congested, but the time had evidently been too short to start inflammation with exudation. Prof. Da Costa kindly congratulated me on the correctness of a diagnosis which he considered to have been, under the circumstances, a rather difficult one; and Mr. B., gave up all suspicions of poisoning.

In this case the abscess was too small and too deeply seated to produce dullness on percussion, and its horizontal position prevented its discovery by a digital examination through the vagina. Then the abscess did not form while I attended the patient, and there were no signs of peritonitis, the tenderness alone excepted, and the latter did not continue. My suspicions would have been, perhaps, earlier aroused, had not the symptoms nearly all vanished after the application of the leeches and with the appearance of the menses. Further, the statement of the patient, that she had been frequently subjected to such pains shortly before her courses came on, misled me. The only sign which made me feel uneasy was the temperature of 105°, and I have often, before and since this case, observed, that if in a disease not connected with abdominal lesions, or in a previously healthy individual, there appears suddenly such a high temperature, with tenderness, pain, and other suspicious symptoms in the abdominal region, these signs, even if existing only temporarily, are always of bad augury, always brood evil, and mostly threaten the presence of pus in the peritoneal cavity, even if the so-called characteristic symptoms of peritonitis should be absent.

Several months ago my friend, Dr. Jos. H. Lopez, a most careful observer and very skillful and cautious diagnostician, called me in consultation, in the case of a boy of about six years. The history, to elicit which was, on account of the remarkable stupidity of the parents and other nursing attendants, perhaps the most difficult task the doctor or I ever had to perform, presented the following facts:—

The child one day complained about pain in the epigastric region, and vomited, since that time, as soon as anything was taken into the stomach. The pain was very severe and constant, apparently, though aggravated in paroxysms every five, ten, twenty minutes, or at longer intervals, therefore very irregularly, and there existed the most exquisite tenderness over the region of the stomach. The tongue was very red, especially at the edges, the pulse rapid but not irregular, the fever moderate. After the child, which had an unquenchable thirst for water, had been suffering this way for about a week, it became very restless and could not sleep at night. The bowels were sluggish. With a great deal of trouble Dr. Lopez found out at last that the child had swallowed a needle two days before the appearance of the symptoms mentioned, and as there seemed to be a circumscribed spot of greatest tenderness near the pyloric orifice, he made the diagnosis of gastritis, —rather local than general in character—and due to the presence of the unfortunately situated foreign body. It looked as if the needle might suppurate out, and as the child by no means made the impression of being dangerously ill, Dr. Lopez expressed himself favorably about the case, but added an "if." After the child had been sick eleven days, and while all the symptoms, notwithstanding appropriate treatment, continued unabated, an epileptoid convulsion set in, and from that time the child had almost every day one or two or more fits. Fever and pulse became irregular, the vomiting and the local tenderness continued, and the bowels were now decidedly constipated. Although there was an absence of a tubercular history Dr. Lopez felt justified in making the diagnosis of tubercular meningitis, or at least meningitis at the base, complicated by the accidental partial gastritis, the latter due to the foreign body, and expressed his new prognosis accordingly. It was then that I saw the case with him. The child would only vomit when anything was taken into the stomach. The abdomen was not retracted, there was no squinting, no local paralysis, nor any other motor or sensory disturbance besides the convulsions. Under treatment the local pain and tenderness seemed to leave gradually, vomiting did not take place so frequently (as mostly in the latter stages of tubercular meningitis), but the convulsions and the irregular pulse and fever continued, and the child became delirious at night. About a week later, therefore, four weeks after the commencement of the disease, the child died. On account of the disagreeable circumstances surrounding the case, as the bad manners of the parents, etc., Dr. Lopez and I withdrew from it six days prior to death; then the pain and local tenderness had totally disappeared. Another physician was called in, who, without further inquiry, ridiculed the idea of stomach disease, and said that it was a plain case of tubercular meningitis, and the child would die. Certainly his diagnosis was correct, but he had not seen the child when suffering from the severe pain and the extreme local tenderness in the epigastric region, and had not thought it worth while to inquire into the history of the case. The post-mortem showed softening of the base of the brain, some effusion there, an occasional patch of lymph, decidedly increased amount of fluid in the ventricles, and serous effusion between the convolutions. Directly across the inner border of the pyloric orifice stuck a rusty needle, covered with lymph, with its point toward the abdominal walls, and the eye imbedded in the submucuous tissue of the pyloric end of the larger curvature. The mucous membrane and parts below were inflamed and swollen for about an inch around.

This case belongs to the second class mentioned in the beginning of this article. A physician seeing the case in the first week only, was warranted in making the diagnosis of acute gastritis, although his suspicions should have been somewhat aroused because no treatment seemed to be of any avail, nothing would relieve the vomiting, while in a common case of gastritis not severer than this was the vomiting can always, after a number of days, at least to some extent, be stopped. That it was no case of local hyperæsthesia in brain lesions was proved by the fact that the tenderness was increased with deeper pressure. The first convulsion was not decisive, as it may have been due to reflex irritation, but as soon as the second appeared and the pulse became irregular the diagnosis of the severer malady was clear enough; especially the last symptom, on which DaCosta lays so much stress, is of the greatest value. I remember several cases where this symptom alone enabled me to make a correct diagnosis, and I have to see the first case in a child yet, where early, and while apparently there seemed to be no special danger to life, an irregular pulse marked its appearance, that the illness later did not develop itself as that fearful malady against which we are so powerless. I hold firmly the opinion that there exists in children two forms of basilar meningitis, and that the one occasionally ends in

recovery. Leaving out acute meningitis following an injury, we have in children one basilar meningitis, which is only seen in connection with a tubercular diathesis and where tubercles are found after death in several organs, and in the cerebro spinal system, especially at the base of the brain—tubercular meningitis, and another, which has no connection with any cachexia, but which is always a complication of a pre-existing disease—simple basilar meningitis, often appearing after whooping cough, typhoid fever, measles, etc., frequently described as congestion, but showing all the elements of inflammation. The tubercular variety, too, follows often after these diseases. The morbid anatomy is the same in both complaints, except that in the simple form no tubercles are found anywhere in the body; and—if this difference really exists—the amount of effusion, especially in the ventricles, is greater, and lymph rarer, than in the tubercular variety. The symptoms also show a slight difference in the simple form: there is not so rapid and neither so much wasting, the vomiting is more constant and stubborn, and the convulsions come earlier and are more frequent. Further: there being no tubercular affection of other organs there are no symptoms to that effect. Sometimes the disease runs a very latent course, and its only symptoms are a few convulsions and restlessness, after which, in a day or two, death ensues. It is always a shorter disease than tubercular meningitis, with which it shares the irregular pulse and fever. I have made three times a post-mortem in such cases, and the most careful research failed to show any tubercular deposit. In one of these, which I saw with Dr. Fricke, there had been no constipation. One case, which could have been called a typical one had the pulse been irregular, but which gave every other symptom of the disease, got well under the administration of large doses of iodide of potassium and the application of a large blister over the head. The child was three years old, and in the sixth day of measles, when squinting, vomiting, and convulsions set in. These symptoms continued for four days, during which the child had taken ten grains of iodide of potassium four times daily and fifteen grains of bromide of sodium, three times daily. On the morning of the fourth day the child had a very mild convulsion, squinting could be observed still, but in a less degree, and the head was moved restlessly from side to side. I then applied a large blister, and while, about seven hours later, the epidermis was raising, the child fell into a quiet sleep, out of which it awoke a convalescent. The case ended in total recovery.

(To be continued.)

DISLOCATION OF THE RADIUS AND ULNA BACKWARD, WITH FRACTURE OF THE CORONOID AND OLECRANON PROCESSES—UNREDUCED UNTIL EIGHT WEEKS AFTER THE ACCIDENT—GOOD RESULTS OBTAINED.

BY W. H. DALY, M.D.,

Senior Physician to the Western Pennsylvania Hospital, at Pittsburg, Pa. Physician for Diseases of the Throat, to the Pittsburg Free Dispensary, etc

Read before the Allegheny County Medical Society, and patient presented.

The patient which I will have the opportunity of presenting to you directly was treated by a respectable member of the profession of this city (not, however, a member of this Society), as a case of fracture of the forearm. There need be no hesitancy about discussing or examining the case, or giving opinions, as I exacted a promise from the patient that there would be no suit for malpractice growing out of it in any way toward my predecessor, who is really, to a great extent, excused by the patient, owing to the great tumefaction which existed before he was called to see the case.

That a Colles fracture existed, though possibly unrecognized, yet, in itself, rather well treated, at least with fair results, is evident to you upon the most casual inspection of the forearm.

That a fracture of the olecranon also existed is well attested by the angular and fibrous union of this process, which can be seen at a glance.

That there was a backward dislocation of the radius and ulna you will infer from the history of the case.

That there was, in addition to this, a fracture of the coronoid process of the ulna you must trust largely to the diagnostic evidence of Dr. W. Wallace and myself, though there still remains evidence of fibrous union of this process below, upon the shaft of the ulna, by careful inspection of the parts.

I bring this case before the Society as an instance of how the swelling and pain in a dislocated and fractured limb of a nervous patient may prevent a, to say the least, not over-careful surgeon from making a thorough examination, and lead to results, if not disastrous to the patient, at least discreditable to surgical art.

We also observe that this very case teaches us the valuable lesson, that when patients will not permit the thorough examination of an injured

limb, then an anæsthetic should invariably be used, in order to arrive at the character and extent of the injuries sustained.

This patient was, as I have said, treated for eight weeks for a fracture of the forearm, and had, as present deformity shows, a Colles fracture of the radius. No passive motion was made use of during treatment, and no attention directed to the elbow, where the injury seems to have been, unsuspected, until the splints were removed, and the patient about to be dismissed. The opinion was then given by the medical attendant that the arm would forever remain useless, unless broken over again. To this the patient's objections were offered, as well as those of the husband, and a wish expressed to seek other advice upon the case, which was agreed to.

The patient, aged 60 years, was brought to my office by her husband, on the first day of May, 1879, and gave, substantially, this history: "That on March 4th, last, about fifty-eight days before, she had sustained a fall upon the icy pavement, when turning a corner of the street; in this fall, as near as she could remember, the weight of her body was thrown upon the palm of the left hand, her head also sustained, on the same side, an injury in falling, and she was picked up insensible. The pain and swelling were great, causing much loss of sleep throughout the subsequent eight weeks, and the swelling came on quickly, and extended to near the shoulder, and was still present to the extent of showing the arm nearly twice the circumference of the other, at the time I first saw her. She did not know what her injuries consisted of, but said the fracture had been located at a point which she herself re-indicated to me, about the junction of the middle and lower third of the forearm.

An examination being quite impossible, from the extreme nervousness of the woman and the painfulness of the arm, which was unable to sustain its own weight, and which was anchylosed in every joint below the shoulder, I advised the patient to go home, after making an appointment to see and examine the case on the following day.

This I did, assisted by my friend, Dr. Wm. Wallace, who placed the patient fully under the influence of an anæsthetic. The elbow was fixed, by anchylosis, at an angle of about 45°, and capable of only very slight motion in the direction of a right angle; all other motion in any of the joints was destroyed by inflammatory anchylosis.

Above the olecranon process, which had been broken, but was re-united in an angular direction by tendinous union, there was a depression, or fossa, very apparent, and which revealed the fact that the lower or trochlear end of the humerus was resting forward of the greater sigmoid cavity of the ulna, and also upon the neck of the radius, a distance three-fourths of an inch in front of its proper place.

The fractured coronoid process could be felt in the bend of the elbow on motion of the arm; it was embedded among the fibres of the brachialis anticus muscle, and the fragment was distinctly movable; there was much extravasation of blood here.

By rather powerful brisement force the adhesions were broken up, and the lower end of the humerus placed in its position in the greater sigmoid cavity of the ulna, care being taken, in this, not to break the tendonous union—as you will see here it is united at an obtuse angle—of the olecranon, as the manifest need for dressing the arm in a flexed position was held in view, in order to get union of the coronoid process as near to its proper seat as possible.

The difficulty in restoring the bones was not great, but when the restoring force was removed the deformity returned.

With the aid of a compress in the bend of the elbow, over the anterior surface of the lower end of the humerus, and padded angular splints, antero posteriorly, the retentive dressing was completed.

In twenty-four hours the swelling was enormous, and the patient bewailed having allowed any further infliction of surgeons and surgery. Leeches, flaxseed poultices and hot rye flour in loose bags, were resorted to to meet the emergencies of inflammatory action, for, following the reduction of the dislocation and fracture, I had done a general breaking up of the anchylosis in every joint, down to the last phalanx.

The dressings were not removed, but the bandages merely slit up, to relieve the tension from swelling, until the end of forty hours, when the pain became so unendurable and swelling so great that I deemed it advisable to remove all dressings, and trust to the infiltration of inflammatory products about the joint to prevent a recurrence of the dislocation of the elbow. Placing the arm on a pillow in an easy position it was enveloped in poultices, and in twelve days after the reduction passive motion was carefully resorted to and persistently kept up. At the end of three weeks the patient drank a glass of water from the hand of the injured arm, which it is not

an exaggeration to say was before entirely useless for all purposes whatsoever, even for sustaining its own weight.

The anchylosis in the fingers was rendered more difficult to overcome, from the fact that there was, and is still, rheumatic enlargement of these joints, and too active motion was apt to be followed by severe rheumatic inflammation in them.

It will be seen that the olecranon process is fractured near its base, and that there was not more displacement is due to the fact that the fascia and periosteum has a retentive power at this point, which is not so available when the fracture is nearer the extremity of the process.

In this accident I have no doubt that the force sustained by falling upon the hand was transmitted through the bones of the forearm, in their line of axis to the elbow, and this momentary force of the superincumbent weight of the body fractured the radius and coronoid process of the ulna first, and the olecranon process was secondarily broken by the opposing action of the triceps, which is inserted into it, or by its being thrown forward suddenly into the fossa of the humerus.

In looking up the literature of fractures of the coronoid process, I find it is an extremely rare injury.

Bryant gives, in his work, a case of fracture of the coronoid process of the ulna. He calls it an uncommon form of accident. He mentions a case as a fracture of the coronoid process of the ulna, with fracture of the head of the radius. He also speaks of fracture of the coronoid process with or without dislocation of the ulna backward, as being extremely rare.

Hamilton speaks of the fracture of the coronoid process as being rare; also, as having only seen seven cases of fracture of the olecranon, in all his experience.

None of the records of these two surgeons and careful observers show a similar case to the one I now exhibit to the Society, combining, as it does, two fractures of the ulna, involving the joint, viz: that of the coronoid process and the olecranon process, with posterior dislocation of the radius and ulna, and Colles fracture. The range of motion, as you see in this arm, is now quite sufficient for ordinary practical purposes; the hand joints are yet a little stiff; the muscles, however, had undergone a fatty degeneration, and did not, at first, perform the slightest contraction under a strong Faradaic current, indeed, one of such a strength as could not now be borne at all. You perceive that the contraction of the flexors is now distinct, up to near the elbow. The treatment is now chiefly the mild, interrupted or induced current of electricity, for the flexors are now mainly out of tone, and the use of rather forcible action of the joints, and encouragement to the patient in using the arm and hand herself. The result is, altogether, a hand and arm with which the patient is quite well enabled to perform any office for herself that can be performed with the other or sound hand and arm, with a somewhat slightly less radius of motion in the elbow joint.

Hospital Reports.

LOUISVILLE CITY HOSPITAL.

CLINIC OF M. F. COOMES, M.D.,

Professor of Physiology and Ophthalmology in the Kentucky School of Medicine.

REPORTED BY A. H. KELCH.

Syphilitic Ptosis.

Most of you will remember having seen this patient on a previous occasion, when both eyes were closed, and the woman was almost unable to speak. You will remember she had almost complete paralysis of all the recti muscles of both eyes, and that there was a little—just a small amount of—mobility of the external rectus muscle of each eye. You observe now she has the left eye wide open, and you perceive she has some motion internally and externally, hence she has considerable power in both internal and external rectus of this left eye.

How old are you? "Twenty-seven."

You see she speaks very clearly. You notice, too, she has improved in her general appearance. She was cadaverous, but now she has a good color, and so far as flesh is concerned she is about as fleshy as she has ever been.

Now, gentlemen, this is an illustrative case. It illustrates the beautiful results of iodide of potassium, of which she is now taking ninety grains per diem. If you remember, I remarked, when I presented her before, that "with her it was iodide of potassium or death." If she was able to take the iodide she would get well probably, that she would be relieved of her paralysis and ptosis, and possibly be restored to her speech. Well, the paralysis is partially relieved, her speech has been restored completely, and I believe that under the continued use of this remedy the ptosis may entirely disappear from the right eye, and that she will finally gain as good control over the right as over the left eye.

Case 2.—Here is a man, a blacksmith, thirty-two years of age, who contracted venereal disease eighteen years ago. Ten days ago his eyes began to get sore, the first evidence being the sensation of a foreign body under the upper lid, near the outer canthus. This is one of the characteristic symptoms of iritis. There is a sharp cutting pain in the eyeball, over the eye, and in the temple. The vision is also impaired. * *

You have heard the history and you see it is

a clear case of syphilitic iritis. He also tells us he has suffered from supra-orbital neuralgia, and in cases of iritis, from whatever cause, you always have that severe supra-orbital pain, and sometimes it is most intense and keeps the individual from sleeping day and night, until he is perfectly exhausted. Now if you were to make an ocular inspection of the eye you would find a material difference in the color of the iris of the affected and unaffected organ. This man has a rather gray-blue eye; the diseased iris gives you a greenish muddy cast. You see there is no œdema of the conjunctiva, simply a redness and congestion. When I saw this man last Monday the pupil was contracted. I ordered him a two-grain solution of the sulphate of atropia and the pupil is now dilated, but it is unequally dilated. The dilatation is incomplete above and below, owing to adhesions between the posterior surface of the iris and the anterior capsule of the lens. He has posterior synechia above and below in the vertical meridian.

Thus far you have the subjective and objective symptoms of the case, with one exception. If you were to examine this man's eye with the ophthalmoscope you would very likely get an imperfect image of the disc and fundus, because of the turbidity of the aqueous humor and because of the great amount of congestion in the retina and choroid. You know the iris is simply a continuation of the uveal tract, which is composed of choroid, ciliary body and iris.

Now, as to the characteristics of syphilitic iritis. When it presents itself in a typical manner it is distinguishable from all other forms of iritis. In all forms you have a change in the color of the structure inflamed. If you see a case in its incipiency, let it be rheumatic, traumatic, or syphilitic, you will find a contracted pupil, with intolerance of light. The pupil, if the case be of syphilitic origin, may be surrounded by little, gray, yellowish-looking nodules, sometimes four or five, surrounding the margin sufficiently to block up the entire opening. Now, whenever you have that condition you may rest assured, no matter how much you may wish to disbelieve it, that it is a case of syphilitic iritis. That is the one point, and the only one, outside of the history, that will enable you to determine whether it is due to rheumatism, syphilis, or some other cause.

Now, as to the treatment of cases of syphilitic iritis. There is one prime object to be kept in view, and that is to prevent adhesions between the lens and the iris, or between the iris and the cornea, because if you allow it to remain contracted it is absolutely certain, in syphilitic iritis, that you will have adhesions, possibly in forty-eight hours. When once the adhesion is permanently formed, the patient will always be liable to subsequent attacks of iritis. Then the prime object is to keep the pupil well dilated.

As to the agents to be employed, atropia is the best. If you simply want to dilate the pupil, a weak solution should be used, but in syphilitic iritis you want, not only to keep the pupil dilated, but you desire, as well, to relieve the pain; then it is best to order a solution of four grains to the ounce of water, and add two grains of morphia, to be used until the pain is relieved, or atropinism produced. I have seen atropinism produced in four hours by a single drop of the solution of only $\frac{1}{8}$ grain to the ounce of water. The subject was an infant, about ten months old. If the pain is not relieved by atropine and morphia you may blister the brow. If it is confined to one side you may blister the whole side of the forehead down to the external canthus, or paint with iodine every few hours until you produce redness or excoriation of the surface. For the constitutional treatment there is but one agent, and that is the iodide of potassium. Give it until the pain is relieved, or until you get iodinism.

Most of the books recommend mercury. I am not an advocate of its use in this particular form of disease. I wish to say that while iodide of potassium possesses the most wonderful power over specific iritis, yet it may be developed while the patient is under its influence. I have seen it occur in this house, in the case of a female who was taking moderate doses. I doubled and tripled the dose in forty-eight hours, and as the symptoms of iodinism developed the disease abated in that eye. The iodide was continued in thirty-grain doses, and in five or six days the second eye began to be inflamed, but it was much milder than in the opposite eye.

Case 3.—Fannie H., age 26. This patient's specific history dates back six years. Three weeks since her throat became ulcerated. Five years ago she was affected in the same way. At this time it is a grave case of specific pharyngitis, involving the left half of the soft palate. Some of you will remember having seen this case a week ago, when the inflammation was at its acme. These cases are sometimes developed very rapidly. One of the first manifestations in cases of this kind is a blush on the anterior surface of both sides of the soft palate—in this instance it was only on one side. This usually lasts eight or ten days, and then it becomes white or presents an ashen hue. If allowed to continue it may remain in this condition for weeks without any enlargement whatever. In other instances it may very suddenly become violently inflamed and slough out, as in this case. Just how much damage may be done it is difficult to say. But as a rule, when saturated with iodide of potassium the disease ceases its progress in eight or ten days. It is not always, however, we get such results. Here is another woman who some three years ago had an attack which was almost identical in its initial lesion with this, and in spite of all I could do, aided by my assistants and colleagues, it went on, sloughed entirely through the soft parts and almost cut the uvula off. This was all done in the course of ten days, notwithstanding she was saturated with iodide of potassium. She had good diet. She had all apparently that was demanded, and yet it went on and resulted as I have just stated. As a result of such inflammation you may have the whole palate cut off, destroyed, and, of course, if that happens the voice must be impaired. In addition to that it may extend up to the pharynx, make its way into the Eustachian tube, and by the contraction which will result from cicatrization lead to permanent and almost total deafness. It is a very rare thing to find

syphilis invading the posterior wall of the pharynx. I think I have not seen more than six or eight cases in my experience, and it is an absolute fact that an ulcer of the posterior wall of the pharynx means one of three things. It means it is syphilitic in its origin ninety-nine times in a hundred. It means that the individual has received an injury, or that it is a cancerous manifestation. I have never seen an ulcer on the posterior wall of the pharynx that was not the result of either syphilis, cancer, or trauma. How long may a patient suffer from syphilis before these symptoms present themselves? Here is a case where it has been six years. I have seen a case where it was fifteen years from the time of the initial lesion until these local manifestations appeared. So it seems as if there were no limit to the time at which the disease may appear in this particular locality. It is impossible to say what structures may become involved. We have cases occurring every day, in which not only the walls of the pharynx but those of the nose and larynx are all invaded in the same patient, but as a rule you find the disease confined to the nose if it first appears there. If it is first manifested in the pharynx it does not usually extend to the nose, but is more likely to invade the larynx. But you may find the nose, pharynx and larynx involved at the same time.

Syphilitic Ozæna.

I want to present these four cases together, that you may see the peculiar physiognomy of each individual. This woman's nose has been sore for a month. You observe how the upper third of it is swollen. She complains of constant headache; she cannot smell anything. She has complete anosmia. Her sense of taste is perfect, but it frequently happens that the sense of taste is much impaired. There is an unpleasant odor emitted from the nose, which in syphilitic ozæna may or may not be detected by the patients themselves. This is an important point, because it tells us that a portion of the olfactory region, if not all of it, is still uninvaded. The olfactory portion, you know, is that part of the membrane covering the superior and half of the middle turbinated bones and the upper half of the septum. On the other hand, if the patient is unable to smell the odor, or after you have cleansed it of all decomposing material, to perceive an odor of any kind, you arrive at the conclusion that the whole membrane lining the cavities of the nose is in a diseased condition, or at least that part of it to which the olfactory nerves are distributed.

Here is a man who, you will perceive at a glance, is deficient about the nose. You see he has a flat face, a condition which any one would present with the bones of the nose absent. This man contracted syphilis eleven years ago. His nose became involved twenty months ago. Several weeks afterward the right side of the pharynx became involved and there was a considerable slough. The disease has gone on from bad to worse until it has destroyed all the bones of the nose. The turbinated and the vomer have been entirely removed. His sense of smell is completely destroyed.

This third man's nose presents, you see, nearly a normal condition, so far as outline is concerned. Three weeks ago it presented a glistening appearance, and it was swollen across the upper part. He says he cannot smell anything but the bad odor in his nose. He denies having had syphilis, but notwithstanding his denial I gave him the iodide. He complained of pain in the nose; there was considerable ulceration and some suppuration. Two weeks ago two of the turbinated bones were removed.

Now, I do not know of anything that produces death of the bones of the nose, aside from traumatic injuries, but syphilis. Polyp, if allowed to grow, may produce such a result, but that I regard as a traumatic cause. In ninety-nine cases out of one hundred you will find syphilitic history if you trace it up carefully. This man is fifty-six years old. You notice that the voice has a peculiar nasal sound. This is said by some observers to be characteristic of nasal catarrh. But I am satisfied if you confine yourself to chronic nasal catarrh you will meet more cases with unimpaired voices than otherwise.

I have noticed that point very closely, and am satisfied of the truth of this assertion. I do not mean to say that the voice is not the least impaired, but an ordinary observer would notice no defect. I saw a boy this morning whose nose is turned to one side, the result of trauma; his voice is entirely changed; he talks through his nose, as the common erroneous expression is, and you might say that boy had catarrh, while really he has none whatever. You may have congenital obstruction of the nasal passages, and then there will be impaired voice. This man has frontal headache, and that is said to be another characteristic of nasal catarrh. This patient has nothing but nasal catarrh, while these others have specific trouble.

As to the treatment, the first and prime object in all cases is cleanliness. What will you clean the nose with? What kind of an instrument will you use? The post-nasal syringe is next best to the atomizer. What solution will you use? Solutions of common salt, of muriate of ammonia, and of bicarbonate of soda. As to strength, you may use from a saturated solution down to ten grains to the ounce of water. Bromide of potassium or muriate of ammonia is an exceedingly painful application when the saturated solution is used, but when reduced to thirty grains to the ounce it is comparatively painless. Care must be exercised as you withdraw the syringe, or you may tear the soft palate. The atomizer, however, is superior to the syringe, and the stream should be directed from it parallel to the floor of the nose. When the fluid has reached the pharynx the patient may draw it back and spit out the secretions with it. This process may be repeated several times, and when you have done with the cleansing agents, soothing or astringent solutions should immediately follow. In those cases characterized by unpleasant odor, a solution of hydrate of chloral is an excellent application. But remember that the prime object is cleanliness. When you have removed all the secretions then you treat the membrane as you would any other mucous membrane in a similar condition.

If you want to drive patients from your office, inject a solution of sulphate of copper, or a strong solution of nitrate of silver. They will derive no benefit from them and will not trouble you again. Weak solutions of carbolic acid combined with chloral or tannic acid produce good results, but the prime object, cleanliness, must not be neglected nor forgotten. After that, soothing astringents will often produce the most satisfactory termination of the disease.

Medical Societies.

REPORT OF THE COMMITTEE OF THE PHILADELPHIA MEDICO-LEGAL SOCIETY (FORMERLY N. W. MEDICAL).

Medico-Pharmaceutical Abuses.

Fellow Members:—In conformity with their duty your Committee now presents the results of its maturer consideration of the medico-pharmaceutical relations between physician and druggist and people, and offer a few hints which, if put into practical operation, your Committee believe, would work as potent correctives of the injuries and disadvantages that we believe are resulting from the broadcast sale of patent and proprietary nostrums by druggists; from prescribing for and treating patients, and unwarrantably renewing and multiplying physicians' prescriptions by druggists; from the increasing and prejudicial introduction of homœopathic specifics, and other irregularities connected with the business systems of medical and pharmaceutical practice.

We desire to first draw attention to some mistakes into which physicians themselves have perhaps unconsciously drifted. In the earlier days of the practice of the healing art, when the professional status of medical men was animated by a higher atmosphere of professional tone and public appreciation, the medical practitioner did not, as in these days, delegate to another class of business men almost the exclusive management of the therapeutics of medical practice. By permitting himself to depend on the druggist more and more, to act in the capacity of his professional aid, the physician has at length realized that the druggist has well-nigh got not only the compounding, but the dispensing lines into his own hands, and is practically driving the medical team for himself.

It is a philosophy of human nature to trust the bridge that carries us safely. By their professional patronizing of druggists, through the latter-day system of prescription writing and sending of patrons to drug stores for all needed remedies, physicians have unconsciously cultivated in most persons, and in all persons to some extent, the habit of greatly relying on the judgment and reliability of druggists for the preparation of remedies for varying phases of ailment; and thus learning to risk the knowledge of the pharmacist, there is developed so much confidence in his discretion and skill, that to a vast degree he, and not the physician, becomes the one consulted for remedies and treatment. Through this means the importance of the physician wanes, the influence of the druggist augments; the prosperity of the professional man is crippled, the avocation of the apothecary prospers; and nevertheless, to the last, the impaired business of the doctor continues to "boost" both the prestige and bank account of the wide-awake pharmacist.

On locating in a new neighborhood, it is the acknowledgment of druggists that their prospects depend on the aid of physicians who will direct patients to take prescriptions to their stores to be compounded, and thus build up the confidence of the community in the probity and trustworthiness of said druggists. But while the alert druggist finds his functions as a compounder thus advanced by the doctors, is he as careful to protect the professional functions of the doctors whose prescriptions and recommendations have established him in the community? Will not some druggists, after being thus aided to substantial standing in the neighborhood, make constant use of their enlarged opportunities to encroach, little by little, more and more, on the legitimate share of the physician's business? And will not some druggists single out a particular doctor as a favorite, and specially "run him," *sub rosa*, as "the physician who gets nearly all the business"? Through this means, have not many competent and valuable physicians found themselves, like Samson, shorn of their professional strength and legitimate incomes, by the Delilahs of a druggist's preference, or a business intrigue? But whom shall we censure; the druggists who thus employ the opportunities afforded them to enhance their individual advantages, or the physicians who have shortsightedly delegated to druggists these valuable advantages?

Another mistake into which we believe regular physicians have drifted is their practice of charging round fees for professional visits merely, even when there is little occasion for such visits, and prescribing unnecessarily large quantities of expensive drugs. This mistake reacts in treble disadvantage to the regular profession at large: 1st. By building up the business of druggists by depleting the pecuniary means of patients. 2d. By promoting the use of proprietary and patent remedies. 3d. By facilitating the alternative of employing the cheaper sugar-pelleted homœopathist. All cases of disease are not desperate, nor even severe. In many instances recovery is certain and speedy, and very little medicine required. If the physician is called, and he charges two dollars for his visit, prescribes sufficient compounds to cost a dollar more, and anxiously renews his two-dollar visit next morning, to see how the prescriptions have worked, to find the patient quite well, although but a dose or two of his bulk of medicines were swallowed; the logical sequence is that on future occasions of slight ailment the druggist will be applied to for a few cents' worth of syrup of rhubarb, or a twenty-five cent bottle of Quachbosh's Ready Cure will be first tried, or Dr. Infinitesimal with his ready-at-hand attenuations will be called in, at a total expense of one dollar. And whose is the fault?

As a rule, persons who are sick, or have friends ill, concern themselves more about the

fact of their restoration than about the particular "ist" or "athy" of the means of restoration. If regular physicians would hold the balance of influence and patronage that deservedly belong to them, with due forecast of policy they must guard the avenues through which these vital advantages may so easily be dispelled.

Another mistake into which some physicians have drifted is that of having smirched the reputation of the profession with the odium of making dirty compact with unscrupulous druggists for a percentage "divvy" on prescriptions diverted to the stores of the latter and made up at excessive prices; bottles and boxes of unused medicines being needlessly set aside by the astute doctor at successive visits, to be substituted by others no less expensive. The shamelessness of such villainous robbery of confiding patrons is only equaled by the professional impolicy of thus laying broad trains of public disaffection through the narrow purlieus of individual good!

Your committee would next draw attention to some sources of complaints of physicians relative to various customs of druggists that injuriously affect the professional and business functions of the medical practitioner. All will agree that sentiments of kindliness and due regard for each other's professional and business province should animate the relations of physician and druggist with each other. Otherwise, under existing usages of treating the sick, the public confidence would be prejudiced and the success of treatment indefinitely impaired. But beyond doubt there are some customs indulged in by various druggists which directly tend to depreciate the confidence and esteem of prescribers. If a physician prescribes a valuable therapeutic like quinine in certain quantities, and the druggist substitutes a less effective alkaloid of bark, he practices a deception on both prescriber and patient that involves a mutual disappointment in results, and robs them both—one of his money, the other of reputation for skill. If, in compounding prescriptions which anticipate standard formulæ, the druggist puts in diluted medications of these instead, both patient and prescriber are again the innocent victims of his unscrupulousness. If, in compounding a prescription, a druggist substitutes a different article for the one prescribed, because the one specified is not in his stock, he practices an arrogant deception wholly at variance with his duties as compounder. If, without being so authorized by the prescriber, the druggist frequently or indefinitely renews prescriptions intended by the physician for temporary employment only, or repeats the use of the prescription by making it up for various persons other than the one for whom it was intended, he assumes an unwarranted responsibility wholly impertinent to the province of his vocation as a responder to the prescribed *dicta* of the physician, who adapted his prescription to the indications of an individual case.

Inasmuch as the abuses of such renewals seriously hazard the physical and moral welfare of patients by continued use of what was designed for but transient employment, the practice of unauthorized renewals merits the uncompromising condemnation of all physicians. There can be no doubt whatever that the opium or morphine, or chloral habit, and also the alcohol habit, have in innumerable instances resulted from these unwarranted renewals of prescriptions by druggists on application of the patient merely. Furthermore, many persons have undoubtedly been permanently injured by overdrugging the system with remedies potent in themselves as correctives of diseased conditions but contra-indicated except where used under the observation of a prudent prescriber.

It is self-evident that, inasmuch as the legitimate business of the druggist is primarily and continuously sustained by the patronage represented through the prescriptions of regular practitioners of medicine, druggists lapse into professional and business malfeasance to the honor of their pharmaceutical alma maters, and especially to the regular practitioners of medicine, if they, the druggists, keep for sale, prescribe, sell, or in any manner act as selling agents for the sale and distribution of quack nostrums, patent and puffed proprietary medicines, or homœopathic specifics of any sort. The injuries to regular practice and the general medical profession that druggists are thus unconsciously working is beyond computation.

As it is the intent of the office of druggist to coöperate with the physician in the dispensing of needed remedies for the treatment of disease, the druggist should perceive that he is guilty of bad faith and business injustice if he intercepts the professional functions of the medical practitioner by prescribing for persons over the counter, or behind the shelter of the prescription case, or recommends and pushes the sale of patent medicines, or in any equivalent manner assumes the office of physician, except as a temporary alternative in pressing emergencies.

It will be perceived at a glance that it is no argument for druggists to affirm that they sell patent nostrums because people call for them, or one sells them or prescribes for persons, because if he don't another druggist will. The wrong of one does not excuse the wrong of another. Was the pushing or sale of patent nostrums the object of the pharmaceutist's studies and graduation? Who is it that has trained the people to go to drug stores for all the paraphernalia of patent medicine makers? Who is it that is ever putting the endlessness of these stuffs into stock and introducing them to the people for a percentage on sales?

All right-thinking minds will agree that any druggist who takes advantage of his opportunity to prejudice the local field of medical practice by collusion with any certain physician, whether that collusion involves the infamous percentage fraud or not, and makes it his aim to specially divert the medical patronage to the one with whom he is in collusion, both such druggist and the "doctor" he "runs" are wholly unworthy either professional or public confidence, and deserve severest professional and public contempt.

Besides the renewals of prescriptions and prescribing over counters, the pushing of patent medicine almanacs and circulars bearing the

imprint of the druggist's business card under every door and into every house, the constant and alluring display in plate-glass windows, in glittering show cases, and upon marble counters, of an endlessness of quack nostrums that profess, upon highly-colored wrappers, to cure every ailment and infirmity, even after all hope has been given up by the doctors; and the increasing sales of these misleading nostrums to all classes of people, are not only proving great injury to the public, but are telling with no unmistakable effect upon the stamina of medical practice. And unless there is some modification in the injurious current of these abuses, the day must soon come when nearly every physician will be compelled to open a drug store for himself, in self-defence!

In conclusion, what shall be the corrective? The answer has been growing more and more self-evident. Let physicians take back into their own keeping the medical advantages, the professional prestige they have so needlessly delegated to druggists. Seek to draw the considerate attention of druggists to the injurious tendencies of these irregularities. Seek by a comprehensive effort to induce all druggists in Philadelphia to shut down at once, one and all, against the flood-tide of patent nostrums, abandon all unauthorized renewals of physicians' prescriptions, and yield all medical prescribing, in cases of disease, to the proper domain of the medical graduate. Prepare and furnish to each physician a list of all druggists who in good faith adopt this reform in pharmaceutical practice, that physicians may know who are worthy of support, and may throw to the advantage of such druggists the entire weight of professional patronage.

If this form of remedy is unattainable, then let every physician manfully cut the Gordian knot of these abuses, by providing himself with all needed remedials and furnishing patients such medicines as they require. Take a vigorous and determined hold of the lines of their own professional knowledge and influence, and drive their medical teams for themselves.

Nothing short of this, your committee believe, will arrest the pharmaceutical wrongs under which both the regular profession and the public welfare unjustly suffer.

ANNUAL MEETING OF THE RHODE ISLAND MEDICAL SOCIETY.

This Society met on the 9th of June. It was called to order by the President, Dr. E. T. Caswell, at 10.25 A.M.

The records of the last annual and quarterly meetings were read and approved.

The report of the Board of Censors was read by Dr. W. O. Brown.

The following were recommended for Fellows: Charles Value Chapin, M.D., of Providence, graduate of the Bellevue Hospital College; George Lewis Wood, M.D., Anthony, graduate of the University Medical College, New York; Charles Durfee Albro, M.D., of Portsmouth, graduate of the medical department of the University of the City of New York.

The following were referred, under the rules, to the next meeting: Eugene Pride King, M.D., of Providence, graduate of the Medical College, Philadelphia; Franklin H. Capron, M.D., of Providence, a graduate of the College of Physicians and Surgeons, New York; Edgar Bronson Smith, M.D., of Providence, a graduate of the same institution; George F. Keene, M.D., of this city, a graduate of the medical department of Harvard University.

This report was received and ordered on file.

The report of the trustees of the Fiske fund was read by Dr. C. W. Parsons, Secretary. From this report it appears that the prize for the year 1880, for the best essay on "The Sympathetic Nerve, its Relations to Diseases," was awarded to Charles Value Chapin, of Providence.

For the best essay on either of the following subjects, for the year 1881, a prize of $150 is offered by the trustees—

1. The action of medicines in the case of disease.

2. Uterine and ovarian diseases as a cause of insanity.

Dr. Chapin was present and was introduced to the members by President Caswell, in a complimentary speech, to which Dr. Chapin responded in a happy vein.

The Secretary, Dr. C. W. Anthony, presented the following report, which was received and ordered to be placed on file.

To the Fellows of the Rhode Island Med. Soc.:

I herewith present my report as Secretary, for the year ending June 9, 1880.

The Society consists of one hundred and seventy-one active members, and twenty-two honorary members.

Ten fellows have been elected since our last annual meeting. Three have died: Sylvanus Clapp, of Pawtucket, S. S. Drury, of Bristol, and Samuel Mowry, of Providence.

There have been held four meetings of the Society during the year, all in Providence.

There have been read before the Society papers by Drs. E. T. Caswell, G. D. Hersey, A. G. Browning, W. E. Anthony, C. H. Leonard, R. F. Noyes.

Diplomas have been issued to Henry C. Hall, Harriet G. Belcher, Isaac B. Cowen, Lucy R. Weaver, James Sullivan.

By the creation of the Library Committee, the duty of collecting exchanges was transferred from the Secretary to the Librarian, and to him all exchanges on hand at the time were transferred.

Respectfully submitted,

W. E. ANTHONY, Secretary.

Dr. Leonard, Treasurer, presented his report, which was received and ordered on file.

The report of the Library Committee was read by Dr. Newell, received and ordered placed on file. The committee had held twelve meetings during the year, and had visited the medical libraries of New York and Boston, to learn the methods and management. The donations and pledges of money and books were very encouraging. The plans of the committee are to secure first, annual contributions to the amount of at least $600, to meet current expenses. Second, to secure a building fund of at least twenty thousand dollars, to be expended in furnishing a place

for the library and a place for holding the meetings of the Society. Donations and pledges to meet the current expenses, amounting to six hundred dollars, for ten years, had already been received. A conditional pledge of one thousand dollars had been made toward the building fund, and other smaller amounts pledged for the same object.

The Librarian, Dr. G. D. Hersey, in a brief report, stated that there were some eight or nine hundred volumes and pamphlets.

The report of the Dinner Committee was made by Dr. C. H. Leonard, stating that dinner would be provided by Mr. George M. Ardoene, at the Hotel Dorrance.

The report of the Committee on Publication was presented by Dr. W. O. Brown, showing that the cost of printing the Transactions of the Society had been $90.31. The report was received and placed on file.

Reports of delegates to other societies being next in order, Dr. Chas. O'Leary, of Providence, reported a satisfactory visit to the New Jersey Medical Society.

Dr. Ballou, of Woonsocket also made a report of his visit to the American Medical Association.

Dr. Bullard, of North Attleboro, addressed the Society as a representative of the Massachusetts Medical Society.

Dr. Job Kenyon, of the Committee on Legislative Petitions, reported that the bill for "Protecting Physicians and Surgeons in giving Testimony" had not prevailed in the legislature.

It was voted that the committee be continued.

Dr. Kenyon, from the Committee on the petition to the Legislature for a bill "Regulating the practice of Medicine," reported that it had failed to secure a passage. It was voted that this report be received and placed on file.

The Committee on the Revision of the By-laws, consisting of Drs. Ballou, Garvin and Hersey, were not ready to report, and the committee was continued.

The Society next proceeded to the election of the following officers for the ensuing year. President—Dr. Chas. O'Leary, vice Dr. E. T. Caswell, declined. First Vice President—Dr. Job Kenyon, River Point, vice Dr. Baker, declined. Second Vice President—Dr. O. C. Wiggin, Providence. Recording Secretary—Dr. Virgil O. Hardon, Providence, vice Dr. W. E. Anthony, declined. Corresponding Sect'y—Dr. E. M. Harris, Providence. Treasurer—Dr. C. H. Leonard. Board of Censors—Dr. David King, Dr. Ariel Ballou, Dr. Otis Bullock, Dr. J. H. Eldridge, Dr. J. W. C. Ely, Dr. W. O. Brown, Dr. L. Morton, Dr. L. S. Keene. Publication Committee—Dr. H. G. Miller, Dr. G. B. Hersey, Dr. Virgil O. Hardon, Dr. R. F. Noyes. Library Committee—Drs. T. Newell, H. G. Miller, G. B. Hersey, Geo. W. Porter, O. C. Wiggin. Dinner Committee—Drs. C. H. Leonard and A. G. Browning. Auditing Committee—Drs. T. Newell and C. W. Fabyan.

The following were elected fellows of the Association: Charles Value Chapin, M.D., Providence; Geo. L. Wood, M.D., Anthony, R. I.; Charles Durfee Albro, M.D., Portsmouth, R. I.

Dr. W. O. Brown, of Providence, read an interesting paper on the subject of "Atmospheric Influence in the Animal System," which was listened to with marked attention.

The President announced that copies of the report of the State Board of Health were on the table and could be had by the members.

At the conclusion of Dr. Brown's paper a recess of five minutes was taken, after which President Caswell delivered his

ANNUAL ADDRESS.

We give a brief synopsis. After an allusion to his pleasure in being once more permitted to address the Society at its annual meeting, and thanking them for the position of honor, he congratulated the Society on the satisfactory report of its Secretary, and then dwelt at some length on the Society's unavailing efforts to secure the desired legislation in respect to expert testimony, to confidential communications of patients, and in regard to the bill regulating the practice of medicine in this State. As to the latter measure, he said it was not in the interest of any school, but was designed to protect our population from sharpers and performers who seek only pecuniary reward. He could not say whether the failure was due to the fact that the Legislature hesitated to encroach upon the divine right of the people to be humbugged, or because the subject had not been put before the Legislature with as much interest as it should be. Other States had made laws upon these subjects, with beneficial results. The principal topic which he considered was that of the public health as it is cared for by the State. Statistics had established the fact that the death rate in the country was 11 to the thousand, and that the corresponding rate in cities should be 17 to the thousand; but when it reached in cities 25 to 40 in a thousand, there was cause for alarm. His subject, which had a wide scope, was not a plant of modern growth. The earliest known writings were by Hippocrates, four centuries before the Christian era. Roman aqueducts, sewers and baths were sanitary measures, and had succeeding generations followed the examples, the horrors of the plague and the smallpox would doubtless have been averted. The University of Edinburgh was the first to add a chair on this subject. England was foremost on sanitary laws and measures. The Paris sewers were built before this, but sanitary science had found better modes. Sanitary science in this country began with the war of the Rebellion, and Americans may be proud of the kind of scientific work done at that time. Many of the leading scientists on this subject were from the army and navy, and first learned the science in the war. There was now a general knowledge that pure air and water are necessary to health.

If the care of the public health was committed to the State Board, they should know that each death represents twenty cases of sickness. It would be their duty to investigate the various occupations of men, their hours of labor, the dampness of dwellings, the purity of the water we drink and of the air we breathe, the lights we burn, the risk of poison paper on our walls, the fabrics we clothe ourselves in, and the toys that our children play with. They should examine our school rooms, in view of their condition as to health, consider the effect of the hours of study. In considering the causes of accidents

by rail, the ability to perceive colors should be noted. The slaughtering of animals with the least degree of cruelty and with regard to the health of the neighboring population, should be looked to. The public should be educated upon this subject, by the spread of circulars and by appropriate lectures.

The men appointed on such a board should be such as had a thorough interest in the work; men of the needed breadth of education; students of sanitary science; men acquainted with the results of sanitary science elsewhere; physicians, who by their acquirements are fitted for such a position; business men, lawyers and a sanitary engineer. Massachusetts was the first State to establish a Board of Health, and there were now twenty-one States that had established such boards. An interesting account of the work of the Massachusetts Board of Health, and of the results of their labors, was given. The result of sanitary measures in New York city was given also. An account, at some length, of the establishment and work of the National Board of Health, and of the efficient results of its work at Memphis, was presented. Illustrations of the evil results of the neglect of sanitary laws were given, in conclusion, the speaker having held the undivided attention of his audience for nearly an hour. He was heartily applauded at the close.

Dr. Caswell then introduced the new President, Dr. Charles O'Leary, who thanked the Society for the honor conferred on him, paid a deserved compliment to the retiring President, urged continued progress in their profession, and promised, by the assistance and forbearance of the Society, to fulfill the duties of his office to the best of his ability.

It was voted, on motion of Dr. Ballou, "that the thanks of the Rhode Island Medical Society be and hereby are tendered to Dr. E. T. Caswell, for the able and acceptable manner in which he has fulfilled the duties of the office of President."

After dinner Dr. Kenyon called the assembly to order, and congratulated the Society on its excellent condition, gave a brief account of its history, and spoke of its hopeful prospects, and announced as the first toast, "The State of Rhode Island." This was responded to by Hon. Abraham Payne, Gov. Littlefield being absent on official duties. Mr. Payne felt it a pleasure to be present on the occasion, and glad to have been selected to respond to this sentiment. He had no need, however, to speak for a State which for more than two hundred years had been accustomed to speak for itself. This State was founded in and built upon an idea, and though we had made great progress, we are a long way from holding accurately to this idea. The whole subject of education, of reformatory institutions, the subject of taxation, the purposes for which property may be taxed or exempted from taxation, are to be examined for the future. Whatever is done in this direction must be done by the educated intellect of the State, and this must depend on the three learned professions of medicine, law and theology.

The next sentiment was "Brown University," which was responded to in a happy vein by the President, Dr. Robinson, who, after some complimentary allusions to the Society he was addressing, dwelt at some length upon the need that, in the possible reconstruction of the curriculum of the education course of our colleges, the men who had received a liberal education, and who knew what was best for them, and what had been mistaken in their education, should aid by their advice in respect to this subject.

The third toast was, "The intimate relation existing between the medical profession and the clergy." This was responded to by the Rev. Dr. E. G. Taylor, in his usual happy vein, in which some pleasing illustrations were used, some good advice given, concluding with the thought that as the physician sometimes felt it his duty to shut out the minister from the sick room, it would be well to have the professions overlap, so that the physician could speak the kind word and point his patients to the faith in the invisible, as well as minister to their bodies.

The toast next in order was, "Our Sister Societies," which was to have been responded to by Dr. Bullard, of the Massachusetts Medical Society, but he was not present.

Dr. Garvin, of Lonsdale, spoke to the toast, "The practice of the medical profession tendeth to charity."

Mr. Albert L. Calder spoke as a representative of the Board of Pharmacy of the State.

The chairman thanked the members for the honor conferred upon him, and the exercises were concluded at nearly 5 o'clock.

Editorial Department.

Periscope.

Successful Removal of a Uterine Fibroid with Thomas' Scoop or Spoon.

The following case was reported in the *Ohio Medical Recorder*, for April, 1880, by E. W. Howard, M.D., of Akron, Ohio:—

Mrs. B., aged fifty-two years, the mother of three children, the youngest twenty-six years of age, had for four or five years been the subject of frequent and severe uterine hemorrhages, so that at times her life had been almost despaired of. During this time she had been under the treatment of a gynecologist, who attributed her flooding to change of life.

In May last, being reduced to the last extremity, she was placed in other hands. Her attendants suspected a uterine fibroid, and upon dilating the mouth of the uterus with sponge

tents, found one of considerable size, of the interstitial and sub-mucous variety, very firmly attached to nearly the whole of the fundus and left side of the uterus. Her physicians decided to remove it with the ecraseur, and anæsthetized her with ether, believing that in her exsanguine condition, with evident heart trouble, the use of chloroform might prove fatal. But she did not get beyond the stage of excitement, and, as they said, fought like a tiger the whole time, a period of nearly three hours. The ecraseur was applied, but when tightened up the chain broke. A silver wire was substituted, and that broke. A silk cord was tried, with the same result. No effect had been produced upon the tumor, and further proceedings were suspended. Her condition was then alarming, a heart clot being feared.

When I saw her I informed her that any further effort, in her condition, would prove fatal, and advised controlling the hemorrhage with ergot, and trying to build her up with iron, quinine, and other tonics, and liberal diet, trusting to the turn of life to give more permanent relief. She improved very slowly, and after several weeks was removed to Akron and placed in my charge. The same treatment was continued, but the hemorrhages were renewed. Ergot failed to arrest them, and I gave dilute sulphuric acid, which did better. I then gave large doses of ergot, with the double purpose of partially extruding the tumor from the uterus and also arresting its growth. It was only partially extruded, but no effect was produced upon its growth. The hemorrhages became more alarming. I could not make the slightest and most careful digital examination without provoking flooding. In this state of affairs I decided to operate at once, but with the gravest apprehensions as to the result, especially fearing the anæsthetic and hemorrhage. Accordingly, on the 28th of October, 1879, assisted by my son, Dr. H. C. Howard, and my friends, Drs. Thomas and L. S. Ebright, I proceeded to remove the tumor in the following manner: After placing her upon the table, we commenced giving her ether, and soon she became almost unmanageable, and fought as before. Then we gave her the A. C. E. mixture (alcohol, one part; chloroform, two parts; ether, three parts), and in one minute she became perfectly quiet. She was then placed in Sims' position, Sims' speculum used, the tumor grasped with strong vulsellum forceps, and Thomas' spoon was gently insinuated between the walls of the uterus and the tumor, when, with a gentle pendulum motion, it was rapidly removed, without the loss of an ounce of blood. It weighed eight ounces. The effect of the chloroform passed off without a single unfavorable symptom, and she was removed from the table and placed comfortably in bed in just sixteen minutes from the time she first went upon the table. She has made a rapid and most satisfactory recovery, without an untoward symptom.

Peptones.

M. Bergeron writes, in *l'Union Médicale* of June 5th, that he has been experimenting with peptones. He has lately had under his care an ill-nourished child, two years old, the mother of whom was thirty-five years old, and the father showed undeniable traces of scrofula. When M. Bergeron saw this child for the first time she was confined to bed, exhausted by a fetid and constant diarrhœa. The lower limbs were affected by lymphangitis. The lungs were not affected; but M. Bergeron suspected fatty degeneration of the liver and kidneys. He put the child on an exclusively milk diet. The stools, which still remained frequent, retained a disagreeable smell. The child's weight varied from 9 to 8.9 kilograms (about 19 lbs.) He attempted to stimulate this frail organism by the aid of alcoholics, which sometimes almost intoxicated the child. He then decided to give her peptones, of which she took at first a teaspoonful night and morning, in broth, increasing the dose to four teaspoonfuls a day. She took this nourishment without any difficulty. At the commencement of the trial she weighed 8.90 kilograms; ten days later on she had gained 500 grams. The diarrhœa might be said to be stopped. Ten days later on the weight remained the same. During that time the child had been troubled by the eruption of two molar teeth, and by a slight recurrence of diarrhœa. In another ten days she had gained 600 grams, and then weighed 10 kilograms (22 lbs.) After the first week of this regimen the little patient had left her bed, and her features regained vivacity and expression. In another case, an adult had been bed-ridden for two years, and had been treated for cancer and stricture of the cardia; which, however, Dr. Bergeron believed to be chronic gastritis with dilatation. This patient had considerable depression of strength, continual vomiting of glairy matters, intermittent epigastric pain, retracted abdomen, notable emaciation, obstinate constipation, and eructations. The tongue was normal. Every kind of drug having been tried in vain, Dr. Bergeron gave peptones, in doses of three spoonfuls daily, in the form of an injection, and as many by the mouth. After the tenth dose the patient was able to get up and walk with crutches. The dose was afterward progressively increased, and she was able to walk in the garden, dispensing with the crutches. This form of treatment is still being continued, and M. Bergeron is in hopes of obtaining a complete cure. He was particularly struck, in the use of this regimen, with the consequent renewal of appetite, especially when the peptone was administered in a little broth in the morning before the patient had broken her fast. He believes that peptone should not be considered as a direct peptogen, but rather as a nourishment which, once received into the stomach, is rapidly absorbed, and leaves this organ aroused to the work of digestion without finding any material for the function. M. Bergeron relates another case, of a nervous and anæmic young woman who complained of disgust for food. He tried tonics, bitters, and nux vomica, without any result. Quite tired of her incessant complaints, Dr. Bergeron at last advised her to take every morning, fasting, a teaspoonful of peptone in a glass of Malaga, as she could not take beef tea. She commenced the treatment the next day, and in an hour she had an excellent appetite, and expressed herself as being obliged to take something. She was so delighted with the result that

she never failed to take a teaspoonful of peptone in a little Malaga wine an hour before every meal.

New Operation for the Radical Cure of Hydrocele.

Dr. Bernard Bartow describes, in the Buffalo *Medical and Surgical Journal* for July, 1880, the following operation, which he has employed in two cases with the most satisfactory results:—

The operation consists of an incision, from three to four inches in length, in the scrotum—in the centre of the hydrocele tumor—extending through the scrotal subcutaneous tissues until the sac is exposed. The loose connective tissue is then separated from the sac to the extent of about an inch either side of the line of the incision, exposing about one-third the circumference of the tumor; the distended sac protruding into the wound renders this last step very easy of accomplishment. Into the most depending part of the tumor thus exposed a fine trocar and cannula is introduced, and the fluid is drawn off, the entire wound being left to close by granulation. It is intended that air shall not be admitted into the sac; and it is preferable to make the incision with antiseptic precautions, and to continue them during its subsequent treatment. In the two cases where this plan was used, the first was a large hydrocele that had received no previous treatment, the second case being one in which repeated tapping had been performed; both patients were young married men, between thirty and thirty-five years of age. The clinical features following the operation were very similar to those following the injection of the sac with tinct. iodine. In both instances the sac had refilled by the fourth day. Resorption was complete by the tenth day in Case 1; in Case 2, however, I did not wait for this event to follow, but retapped the sac through the wound, on the sixth day, after which it did not re-fill. The degree of inflammation in the scrotal subcutaneous tissue and sac was quite active in the first case, but the free incision of the operation prevented any tension in the part, and there was no sloughing of scrotal tissue, or any other untoward feature. On this occasion no special antiseptic measures were observed.

In the second case, however, strict antiseptic precautions were employed throughout, with the effect to confine the inflammatory action within very moderate limits.

A Case of Mixed Astigmatism, Supposed to have been Caused by the Sucking of the Eye by an Infant.

The following interesting case is reported in the *Medical Record*, July 10th, 1880, by David Webster, M.D., of New York:—

On May 20th, 1873, Dr. C. R. Agnew was consulted by a lady, thirty-six years of age, on account of impairment of vision of her right eye. The commencement of her trouble dated back about eight years, when she first noticed a straight black line running obliquely across the right visual field. This line soon became crooked, and was broken up into numerous transparent specks. These floating, transparent globules eventually mostly disappeared, and the eye, after many months, settled down into a condition in which all objects seemed "distorted" and everything was "double lined." "The gas-flame," she observed, "had a halo with radii about it." She has not now, nor has she ever had, any external appearances of inflammation or irritation.

At the time the trouble was ushered in the lady was weaning her babe, and, curiously enough, fell into the habit of allowing the little one to suck her right eye as a substitute for her nipple. She positively affirmed that almost every night for six months she allowed the child to go to sleep resting on her right arm, and with his mouth applied to her right eye. This gave her no pain, and she indulged the child in it, not thinking it would do her any harm. She now believes that the trouble in her eye was induced by the long continued and often repeated suction exerted on the eyeball by the mouth of her child. Examination with the ophthalmoscope reveals nothing abnormal except astigmatism. Without a glass the vision is $\frac{8}{10}$, but is raised to $\frac{20}{20}$ with $-\frac{1}{10}$c. axis 70° $\supset$ $+\frac{1}{4.5}$c. axis 160°. The fellow eye has vision $\frac{20}{20}$, and is emmetropic.

Whether the frequently repeated and long continued suction applied to the eye had anything to do with the change in its shape is a difficult problem to solve. For my own part, I am inclined to think that it did. It is certain that the astigmatism was developed during the period in which the eye was habitually subject to suction. It may be objected that the traction would affect only the loose and yielding eyelids. It seems to me probable, however, that the lips of the child would often make more or less pressure upon the eyeball anterior to its equatorial region. This seems to be borne out by the history of the case, for there seems to have been a slight hemorrhage into the vitreous, probably caused by intermittent pressure upon the globe.

Tinea Tonsurans Accompanied by Alopecia Areata.

The following report of a case, by Alfred Sangster, M.B., occurs in the *Lancet*, July 3, 1880.

J. G., aged seven, according to his mother's statement, first had ringworm about twelve months ago; his sister had ringworm three years ago. The patient came to the out-patient department with well-marked diffuse ringworm (chiefly over the occipital region,) the affected surface being scaly and sparsely covered with hairs, some long, some short and stubble-like. Below and to the left of the superior angle of the occiput was a round patch of alopecia areata about the size of a crown piece. The patch had not quite the typical appearance of the last-mentioned disease, being somewhat pink and to a trifling degree rough; toward its margin were recognized the short, clubbed hairs characteristic of alopecia areata, while immediately beyond, for the greater part of the circumference of the patch, was the ringworm surface before alluded to.

Microscopical examination of such scales and debris as could be scraped from the bald surface showed epithelial scales with a few groups of spores, like ringworm spores. Examination of the clubbed hairs showed them to be highly pig-

mented, almost opaque. As regards the presence of fungus, nothing like the trichophyton was seen, but in such hairs as were less opaque there was a certain granular appearance (Hart. oc. 3; obj. 8 tube out), the granules in places being arranged in wavy lines, as if packed between the fibre-bundles of the hair. The specimens were mounted in glycerine, and still show the above appearances. Abundance of ringworm fungus was found in the hairs in the immediate proximity of the alopecia patch.

In the Pathological Society's Transactions (1874, p. 209), Mr. Waren Tay has recorded a case of alopecia areata associated with ringworm. In his paper similar observations by Hutchinson, Hillier, and Fox are alluded to, so that it would seem that the association is not a remarkably rare occurrence.

In the above-narrated case the presence of spores, like ringworm spores, among the debris scraped from the bald patch, might have been accidental, considering the proximity of the ringworm. However, most observers have found fungus like the trichophyton in the bald patches complicating ringworm. The question then arises, are the bald patches true alopecia areata? bearing in mind how rarely (if ever) fungus is detectable in uncomplicated cases of the latter affection. If true alopecia areata, the further question suggests itself, has this disease any relation to ringworm? And if so, what relation? Mr. Hutchinson has, I believe, long been decided that a relationship exists between the two diseases in question.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the *Virginia Medical Monthly*, for May, 1880, contains an article by Edw. C. Mann, M.D., on "The Brain in Health and Disease."

——Dr. A. B. Watson, of Jersey City, in a neat little pamphlet, discusses "The Proper Period for the Performance of Amputation in Cases of Traumatic Injuries."

——"Medical Ethics" is the subject of a well-written thesis, by A. N. Wylie, M.D., which was read before the Brown County (Ohio) Academy of Medicine, in Ripley, Ohio, February 19th, 1880, and now comes to us in pamphlet form.

——We have received in pamphlet form a reprint from vol. iv of the Gynecological Transactions, 1880, containing Clinical Notes on the Elongations of the Cervix Uteri, by William Goodell, A.M., M.D.

——We acknowledge the receipt of the "Second Annual Announcement of the College of Physicians and Surgeons," of St. Joseph, Missouri, and also of the first number of the St. Joseph *Medical and Surgical Reporter;* edited by J. P. Chesney, M.D. It is a monthly journal, and the subscription price is $2.00 a year, in advance.

——An essay on "The Time of Conception and Duration of Pregnancy," by George J. Engelmann, M.D., comes to us in the form of a reprint from the St. Louis *Courier of Medicine*, May, 1880.

——The August number of the *United Service*, a monthly review of military and naval affairs, contains numerous interesting articles, among which are: "Collisions at Sea," by Lieutenant Seaton Schroeder, U.S.N.; "Military Landmarks," by Lieutenant James Regan, U.S.A.; "Naval Education," by Lieutenant T. B. M. Mason, U.S.N.; "Employment of Troops in Garrison," by Captain H. C. Cushing, Fourth Artillery; The English Naval Prize Essay, 1880 (concluded), by Capt. the Honorable Edmund R. Treemantle; etc., etc. It is published by L. R. Hamersly & Co., 1510 Chestnut street, Philadelphia. Price 50 cents a copy, or $5.00 per annum.

BOOK NOTICES.

A System of Medicine. Edited by J. Russell Reynolds, M.D., F.R.S., Professor of the Principles and Practice of Medicine in University College, London; with numerous additions and illustrations by Henry Hartshorne, A.M., M.D., late Professor of Hygiene in the University of Pennsylvania. In three volumes. Philadelphia, Henry C. Lea, Son & Co., 1880. Vol. III, 8vo, pp. 986. Price, per volume, in cloth $5.00; in leather, $6.00.

The third volume of this excellent work treats of diseases of the Digestive, Blood-glandular, Urinary, Reproductive and Cutaneous Systems. As in the preceding two volumes, each subject has been treated by some gentleman who is regarded as its highest authority. Chapters on cholera morbus, cholera infantum, trichina spiralis, bronchocele, progressive pernicious anæmia, and spermatorrhœa have been added by the American editor. The numerous illustrations in this, as well as in the preceding volumes, are well executed, and nothing seems to have been left undone to render the work not only one of the most thorough treatises on medicine, but also an ornament to any physician's library. Each volume is furnished with a separate index, and also with a list of the chief authors referred to in each article, and a general index for the three volumes has been appended to volume III.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE MEDICAL ASPECTS OF EDUCATION.

IV.—Business Education.

In this country the young man is generally left to choose his own avocation. His selection is usually influenced by the merest chance, as by some casual impression, the presentation of a favorable opening, or by the action of some friend.

There are not wanting defenders of this happy-go-lucky system. We once heard the president of a famous college say, that in his opinion it made little difference what profession a young man chose; if he had the right stuff in him, he would succeed in any; if he had not, he would fail in all. This probably expresses the general American opinion on the subject.

On the other hand, we heard a German professor, who had made the practical science of education his life study, say that a close and skilled observer could almost always detect, at as early an age as fifteen or sixteen, the aptitudes and disqualifications of a boy for the several careers open to him, and that the business or professional training should begin then, with a definite purpose.

We are more inclined to the latter opinion, as the more philosophical, the more educational of the two. Physical as well as mental factors come into the problem. All arts and handicrafts can only be carried on with good success by those with certain physical requirements.

Many a physician fails through an unready nervous system; many a lawyer through an uncontrollable diffidence. Their lives are made painful and their successes won by extravagant draughts on their powers.

Professor Virchow, in his address on medical education, at Amsterdam, last year, bewailed the absence of the faculty of observation among his medical students. As he expressed it, he would show them something a dozen times, and yet they could not see it. Such men, he pointed out, had chosen the wrong vocation. They were not calculated to succeed as physicians; they should have selected another life-work.

Hereditary tendencies should be considered in selecting a business. Certain trades, certain professions are liable to exaggerate the inborn tendencies to deterioration. Any one would appreciate the danger of a man going into the liquor business who inherits a love for alcoholic stimulants. To a less degree this is true of very many constitutions. The broad distinctions between sedentary and out-door pursuits, between those which are consistent with regular hours and those which involve irregularity, are obvious enough. The nervous and worrying temperament is not well suited for speculative affairs.

How many men in this country break down in middle life? How many you can remember have had to give up this or that pursuit after years spent in its study and practice, because "their health gave way!" It is not altogether because our American life involves greater strain than that in other civilized lands. It is chiefly because the man who succumbs to the demands of a business never was physically fitted for that business, and if his powers had been accurately gauged, should never have gone into it.

Certain avocations are in themselves unhealthy; others involve a certain amount of extra hazardous risk. All are essential to the general development of a country, but the dangers in all can be greatly lessened by a proper selection of the persons who shall enter upon them. A striking example of advance in this direction is presented by the recent investigations into color blindness. It has been found that a rather large percentage of employees on ships and trains are not able to distinguish between the colors used as signal lights. Here is a case where medical science steps in, in an unexpected manner, to prevent danger not only to the individual but also to very many others, by informing him that he is not qualified to fill the duties of the position he occupies.

The uniformity of the methods of education in this country tend to obliterate, to a certain extent, the native individuality of each scholar. It may well be doubted if this is a benefit. In fitting all to be anything, the system runs the risk of disqualifying all to excel particularly in anything. The physician, whose observation is so often directed to the power of idiosyncracy, would rather recommend that the peculiarities of a scholar be preserved and directed in that channel which will give them their greatest power for good. Muscular power, acuteness of the senses, the nervous equilibrium, the balance of the circulation, and similar plays of function, differ vastly in individuals, and no amount of training can overcome this difference of gifts. They are ancestral heirlooms, not possible wholly to alienate. It would seem most wise to estimate them, and to let them come into the reckoning in the working out such a vital problem as that of the means of subsistence. We ask for them more attention than we are accustomed to bestow in this country.

Notes and Comments.

Therapeutical Notes.

TREATMENT OF ERYSIPELAS.

According to the Dublin *Journal of Medical Science*, for May, 1880, Hüter, of Greifswald, attributes erysipelas to bacteria, and successfully treats it with hypodermic injections of carbolic acid of the strength of three per cent. These should be used when the first symptoms appear, and then two or five injections are sufficient. At the same time the wound should be treated antiseptically, and if it have an unhealthy appearance, a solution of chloride of lime (five or eight per cent.) should be employed.

SALVES OF SALICYLIC ACID IN ECZEMA.

The Edinburgh *Medical Journal*, for May, states that Dr. Von Geuzer recommends their use, in the strength of 4 to 100, in the moist eczemas of children and in intertrigo. Under their use the affected parts soon became dry and the skin paler and scaly.

Foreign Body in the Rectum.

A correspondent, writing from Paris, states, in the *Lancet*, July 3, 1880, that at a recent meeting of the Société de Chirurgie, M. Verneuil showed a block of wood which he had removed from the rectum of a patient. The subject of M. Verneuil's communication is a wood cutter, who has suffered for some years from dysentery, with incontinence of fecal matters. To remedy this he was in the habit of introducing into the bowel a plug of wood wrapped in a linen cloth, of which the ends were allowed to protrude. But on one occasion, having forgotten these appliances, a portion of a branch of a poplar, cut roughly conical with the axe, was made to serve the same purpose. While at work this was suddenly felt to move upward, and in spite of the patient's endeavor to arrest its progress, it disappeared entirely into the rectum. When consulted M. Verneuil was unable to detect any foreign body by digital examination, but palpation revealed the existence of a hard lump, as it seemed, in the sigmoid flexure. He accordingly determined to open the abdominal cavity, to draw out the gut, and incise it, as in the operation for gastrostomy, intending to put in carbolized sutures, and to return it if healthy, but to make an artificial anus if necessary. When, however, the abdomen was opened, it was ascertained that instead of being in the sigmoid flexure, the wood had remained fixed in the upper part of the rectum. It was then found that it could be moved downward, although with great difficulty, and when pressure was made upon it by M. Verneuil from above, M. Lucas-Championnière was able to reach it with the finger through the anus. After some unsuccessful endeavors to pierce and extract it with a gimlet

and forceps, a pince de Museux was disarticulated, and one of the blades used alternately as a level and a tractor. To render this manœuvre more easy linear rectotomy was practiced with the thermo-cautery, and after considerable trouble, the block of wood was ultimately extracted. An examination of the rectum then showed that the difficulty of removal had been due to an extreme swelling of the mucous membrane to a hard œdema, which was no doubt caused by the obstacle placed in the way of the return circulation by the foreign body. Thanks to an antiseptic, or, to be more precise, a Listerian dressing, the subsequent progress of the case was most satisfactory.

Treatment of Poisoning by Strychnia.

Dr. Q. C. Smith, of Austin, Texas, lays down, in the Nashville *Journal of Medicine and Surgery*, for July, 1880, the following rules for treating cases of strychnia poisoning:—

If the patient is seen in time for an emetic to be of service, give forty grains ipecac—not tartar-emetic, or any irritant emetic—and follow immediately with large draughts of plain, warm water; place the patient in a warm bath and encourage emesis by tickling the fauces. If the patient is already in convulsions, administer chloroform by inhalation until the spasms are subdued, then give the ipecac and warm water. As soon as the emetic has acted give the following:—

℞.	Hyd. chloral,	℈ j–ij
	Bromide lithium,	gr. x–℈ j
	Simple syrup,	℥ j. M.

Ft. sol.

Sig.—Give at one dose, in a little cool, sweet water.

Repeat this dose as often as the case demands. Give the patient frequent small drinks of plain, cool water. Apply a *weak* galvanic current, mobile along up and down the spine and limbs, through a large sponge electrode, moist with warm salt water. These remedies should be continued in such quantities and frequency as to hold the convulsions in abeyance until the poison is eliminated from the system. Strong galvanic currents, oils, acids, or spirituous liquors should not be used. As germane to our subject, we would note the fact that the old California miners, who in early mining days were often closely pressed for food, sometimes ate mushrooms, and occasionally poisoned themselves by partaking of the wrong variety, but found an unfailing antidote by drinking tobacco tea sufficient to cause vomiting. If the tobacco proved alarmingly depressing, warm whisky toddy was given until the crisis was past.

The Antipathic Effects of Tartar-Emetic.

Dr. A. G. Hobbs says, in a communication to the *Indiana Medical Reporter* for June, 1880, that he was first led by accident, rather than by any exercise of reason, to try tartar-emetic in minute doses as an anti-emetic, and that he has since used it successfully in a large number of cases, of several of which he gives the history. He concludes by saying—

"I have used this treatment only when the stomach was empty from long-continued vomiting—when nothing was ejected but a viscid, frothy mucus; in singultus attending low forms of fever this treatment is equally efficacious. I do not offer any *rationale* of this effect of tartar-emetic, because I do not know any, but simply give the results of my own experience during the last three years. May it not be due in a measure to the neutralizing effect of the drug upon the mucous secretion of the stomach, which contains a certain ferment? or may it not be due to a tonic action upon the terminal nerve fibres?"

A Case of Superfœtation.

Dr. D. A. Walden, of Beatrice, Neb., states, in a communication to the Chicago *Medical Journal and Examiner*, for July, 1880, that he was called at 3 o'clock, P.M., on the 19th of April, to see Mrs. G., aged 20, primipara, and married about ten months. After a short but severe labor, she was delivered of a healthy, full-termed female child of about five pounds weight. The placenta was delivered without any unusual difficulty. He called on the following morning and found the patient in good spirits and free from pain.

About 9 o'clock P.M., on the 21st, while using the vessel, there passed from her a complete, unruptured sac containing a male fœtus and placenta, in appearance of about four months' gestation. The following afternoon saw her in an easy and painless condition.

She has made a rapid recovery, and the child is healthy. Upon questioning her, she stated that she had her menstrual flow for three or four months after she was aware of her pregnancy. A close inspection revealed no evidence of a double uterus.

Drunkenness and Suicides.

The *Medical Times and Gazette* informs us that from statistics collected by a director of an Asylum for Drunkards in Germany, the number of suicides has lately increased in every country in Europe, except Norway only. In Norway there

has been an average of 9 per cent. fewer cases of suicide during the last ten years than in any preceding ten years—a fact which the German writer attributes to the stringent regulations against drunkenness in force there. In most German countries suicides have increased from 90 to 100 per cent. For each million of inhabitants there are, on an average, every year in Saxony 300 cases of suicide, in Denmark 280, in Würtemburg 180, in Mecklenburg 167, in Baden 156, in Prussia 133, in Austria 122, in Bavaria 103, in Sweden 81, in Belgium 73, and in Norway 40.

Priapism in Leucæmia.

Dr. Salzer relates, in *Berl. Klin. Woch.*, No. 11, 1880, the case of a saddler, forty-six years of age, suffering from leucæmia, probably of splenic origin. Without apparent cause he became subject to priapism—at first only of short duration, but which afterward became persistent for six weeks. It was then followed by the opposite condition, one of absolute impotence. Analogous cases of prolonged priapism are to be found in medical literature.

A Monstrosity.

Dr. D. C. Randle, of Crawford, Miss., writes us that on the 17th of May last he delivered a negro woman, in the seventh month of pregnancy, of a female monster, with two well-developed heads and faces on one neck and body. There was only one set of limbs, but two spinal columns, which came together like the letter **U** at the last lumbar vertebræ, ending in one sacrum and coccyx.

Correspondence.

Puerperal Fever in the Southern States.

Ed. Med. and Surg. Reporter:—

In the report of the proceedings of the Pennsylvania State Medical Society, as published in the Medical and Surgical Reporter, of June 12, 1880, on page 515, occurs the following paragraph, in an abstract from a paper on Puerperal Septicæmia, read before the Pennsylvania State Medical Society by Dr. W. H. Parrish, of Philadelphia:—

"Malarial fever renders a patient more liable to septic poisoning. Probably both the scarlatina and the malarial poisoning may establish degenerative inflammation in slight wounds of the pelvic tissues, and thus lead to septic poisoning. This, probably, accounts for the greater frequency of puerperal fever in the Southern and malarial States."

In this particular malarial region we have always taken an opposite view of the case, and considered that malaria modified, if it did not altogether exclude, many of the septic poisons. Among others, we considered ourselves remarkably free from puerperal fever. It will be news to us, therefore, to hear of "the greater frequency of puerperal fever" in this locality than in Northern cities.

I trust, however, that this will prove to be only one of those rash statements, founded rather upon fancy than figures, which have done so much harm to this section of the country, and which upon critical examination may be found to be incorrect.

As a matter of interest, therefore, to your Southern readers, would you not kindly publish the data upon which Dr. Parrish founds this statement? And, as bearing upon this subject, I append a table of the mortality from this disease in this city, from 1854 to 1869, from official sources:—

Year.	Whites.	Blacks.
1854	2	...
1855	...	...
1856	...	...
1857	...	...
1858	1	...
1859	1	...
1860	...	...
1861	3	1
1862	1	2
1863	3	...
1864	2	2
1865	...	1
1866	4	4
1867	2	3
1868	3	5
1869	3	2
Total	25	20

The statistics since 1869 are not so easily accessible, and further, there was undertaken about this year ('69) an extensive system of drainage which has entirely changed the complexion of the prevailing diseases.

It will be noticed that before the war this disease was almost unknown, there having been but four deaths in seven years, and those were among the whites, while there were none among the negroes. The four war years ('61, '62, '63, '64) show a great relative increase, nine whites and five blacks, while in the last four years ('66, '67, '68 and '69) the white mortality from this cause was 12, and that of the blacks 14.

Now, when it is remembered that all this time the malarial character of our diseases was lessening, and much more attention was paid to what is called hygiene, I think some other cause must be sought to account for the great increase of this disease in proportion to its former prevalence, more especially among the negroes, who are least subject to malarial influences.

Savannah, Ga. R. J. Nunn, M.D.

News and Miscellany.

Regulation of the Sale of Patent Medicines in Japan.

The *British Medical Journal*, July 3, 1880, observes:—

In respect to the sale of patent medicines, we might advantageously take a lesson from the

Japanese. We learn, from the first report of the Central Sanitary Bureau of Japan, just issued, that they have established a public laboratory for the analysis of chemicals and patent medicines. The proprietors of patent medicines are bound to present a sample, with the names and proportion of the ingredients, directions for its use, and explanations of its supposed efficacy. During the year there were no fewer than 11,904 applicants for license to prepare and sell 148,091 patent and secret medicines. Permission for the preparation and sale of 58,638 different kinds was granted, 8,592 were prohibited, 9,918 were ordered to be discountenanced, and 70,943 remained still to be reported on. The majority of those which were authorized to be sold were of no efficacy, and but few were really remedial agents. But the sale of these was not prohibited, as they were not dangerous to the health of the people. If similar regulations were put in force in this country, it is probable that the sale of several patent medicines would be put a stop to.

Growing Fat on Air and Water.

"Dr." Tanner, who is trying to fast for forty days, completed his twenty-first day on July 19th. Up to that date it is alleged that no food had passed his lips, and that, until a few days ago, he had not even taken water except to rinse his mouth with and to bathe. During the time that he abstained from water he lost twenty-four pounds of flesh, and death seemed near, but since he has been taking water freely, it is stated that he has been gaining in weight daily, and that his health has been excellent.

Some of the daily papers contain, at present, numerous stories of similar feats of prolonged fasting, and as he has received a challenge for a fasting match, to come off as soon as he gets into proper trim again, the sporting world will probably have the monotony of walking matches relieved by a fasting match.

QUERIES AND REPLIES.

Dr. J. I. B., of Texas, wishes to know whether there is a *Chlorate of Chromium*, and, if so, whether it is a safe, effectual and comparatively painless caustic.

Ans.—There is, we believe, no such compound in the market; but the *chloride*, or rather the *sesquichloride* of *chromium*, when used in its crystalline form, finely powdered, is said to be comparatively painless, but we have had no experience with it.

Dr. I. A. F., of Pa.—Simple elixir is prepared by mixing—

℞.		
	Spirit of orange,	ʒij
	Spirit of cinnamon,	♏x
	Alcohol,	ʒiv
	Simple syrup,	
	Water, each	ʒvj.

Dr. C. G., of Conn.—Dr. J. N. Page, of Marshfield, Warren Co., Ind., states that, by following the plan of Dr. Coover, as delineated in the MEDICAL AND SURGICAL REPORTER, Oct. 11th, 1879, failure will be impossible. He says that he has applied a number of plaster-of-Paris jackets and only two of the silicate of soda jackets, and that he has succeeded so much better with the latter in treating spinal disease, that he never expects to use the plaster-of-Paris again. There is, he says, no trouble to get the soda to adhere, if you have it the proper consistency. He uses it as thick as he can make it, by adding warm water and keeping it warm while applying it. After it is thoroughly dry, water will not soften it, nor is it liable to crack or crumble. One which he applied to a young boy, last February, has been worn every day since with perfect comfort, and its weight is only a little over two pounds.

Dr. Henry P. Wenzel, of Lomira, Miss., writes that, as soon as the silicate is dry, and has "set" perfectly, the jacket should be varnished on both inside and outside. Sweating can be ameliorated in those unfortunates who wear jackets of silicate (or plaster) dressing by strengthening the jacket with long, narrow strips of sheet tin, and when dry, punching the jacket full of small holes, which allow egress to the moisture and ingress of a "little cool air;" then varnish both sides, but keep the holes (punched) open. If the punching is carefully done, there is no danger of breaking or cracking the silicate—at least, in his experience. Also, let the jacket be worn as a corset, and remove it, say once daily, and sponge the covered surface with pure vinegar, and the sweating will be less profuse.

MARRIAGES.

CHAMBERS—MATHER.—At Port Jefferson, L. I., on June 24th, by Rev. W. S. O. Webster, M. L. Chambers, M.D., and Sadie J., daughter of John R. Mather, Esq., all of Port Jefferson.

DUNLAP—THURBER.—In West Lebanon, Vt., May 9th, by Rev. A. B. Rich, D.D., Dr. Wm. H. Dunlap and Mary D. Thurber, of Syracuse, New York.

FINNEY—PHELPS.—At the M. E. Church in Rodman, N. Y., June 9th, 1880, by Rev. C. Phelps, assisted by Revs. A. C. Danforth and M. N. Capron, J. R. Finney, M.D., and Hattie A. Phelps, daughter of the officiating clergyman, all of Rodman, N. Y.

HENRY—MAYNARD.—At Boston, 24th ultimo, by the Rev. W. W. Newton, Dr. Morris H. Henry, of New York, and Mrs. M. L. Maynard, of Boston, Mass.

HERRICK—FORD.—On Thursday, June 17th, 1880, at the residence of the bride's father, by the Rev. William Adams, D.D., Harriet, daughter of John R. Ford, Esq., and Everett Herrick, M.D., all of New York.

HILTON—ABELL.—At the residence of the bride's parents, Antwerp, New York, Thursday, June 17th, by the Rev. J. J. Hough, Archibald L. Hilton and Mary Abby, daughter of Ira H. Abell, M.D.

REESE—LIVINGSTON.—At the home of the bride's father, June 3, 1880, by P. J. Timlow, D.D., assisted by I. M. Gable, Dr. C. I. Reese, of Atglen, Chester county, Pa., and Hattie E. Livingston, of Gap, Lancaster county, Pa.

SALISBURY—RANSOM.—At the residence of the bride's parents, in South Orange, N. J., by the Rev. J. H. Worcester, Jr., Francis B. Salisbury and Mary M., daughter of A. A. Ransom, M.D. No cards.

SHEPHERD—TACKETT.—At Richland, Holmes County, Miss., on Wednesday evening, June 23d, 1880, by Elder Mat. Lyon, Banks A. Shepherd, M.D., and Miss Mollie B., daughter of Judge J. P. Tackett.

VAN VALZAH—VAN VALZAH.—At Spring Mills, Pa., June 23d, 1880, by Rev. J. D. Wilson, D.D., Franklin H. Van Valzah, M.D., and Miss Jennie Van Valzah, all of Spring Mills.

DEATHS.

BRISBANE.—Entered into rest, in this city, July 7th, 1880, William Brisbane, M.D.

EMANUEL.—In this city, July 2d, Manly Emanuel, M.D., eighty-six years of age, ex-president of the Delaware County Medical Society,

LALOR.—At Bow Hill, near this city, on the 4th inst., Mamie J., only daughter of Dr. Wm. S. Lalor, aged 7 years.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1222.] PHILADELPHIA, JULY 31, 1880. [Vol. XLIII.—No. 5

Original Department.

Lecture.

V. PULMONARY PHTHISIS.

Delivered at the Philadelphia Hospital, December 17th, 1879,

BY WM. PEPPER, M.D.,

One of the Physicians to the Hospital, and Professor of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WM. H. MORRISON, M.D.

Gentlemen—I think it will save time, if, instead of considering further the course and symptoms of phthisis, I to-day ask your attention to the treatment of those symptoms we considered at my last lecture. I will, therefore, for a moment return to and take up the treatment of the fever in chronic catarrhal phthisis. You will remember that I spoke of its irregular course, differing in different individuals; being in some very marked, while in others it was very slight. This does not appear to depend upon the amount of local disease, since in some systems a comparatively small amount of local disease will be attended with a high degree of fever, while in others a much more extensive local disease will be accompanied by a very slight elevation of temperature and increase in the pulse rate. Undoubtedly, an explanation of a part of this great difference is found in the fact that different individuals get fever with different degrees of ease, owing to some difference in the nervous organization of the individual; but in addition to this, there is reason to fear that in cases attended by much fever there is danger of the absorption into the system of some irritating or septic matter, so that this fever is, to a certain extent, of a septic or zymotic character. As a rule, in those who present a considerable degree of fever in proportion to the local lung trouble, we are to dread the development of tubercle. Thus, it is an unfavorable prognostic sign.

I further told you that, in any given individual, the fever, from time to time, presented remarkable fluctuations. The true nature of these exacerbations is frequently overlooked. The patient is said to have a bilious attack, a little chills and fever; almost every other explanation than the true one, which is, that it is due to a fresh attack of pulmonary catarrh; and examination will show that with each attack there has been a distinct extension of the area of catarrhal irritation and an increase of the inflammation. Therefore, when a patient with catarrhal phthisis gets increased fever, no matter what the other symptoms may be, whether associated with disturbance of the stomach, loss of appetite, diarrhœa, or not, I advise you to suspect the existence of a fresh attack of catarrhal inflammation, and treat it accordingly. In such patients there is a most intense susceptibility to the action of damp, cold, and other disturbing influences, so that a catarrhal attack is set on foot by an amount of exposure and with an ease that seem scarcely possible.

The treatment, then, of this febrile action is a matter of the greatest importance. In the first place, let us recognize that it is distinctly connected with the irritation of the local disease, and that when it is very high in proportion to the local disease there is reason to fear that infection of the blood and system is going on. We must also bear in mind that there is nothing in the condition of a patient with catarrhal phthisis which would prevent him from suffering from malaria. Indeed, such a person would be very

liable to be attacked by malarial fever, if exposed to its cause; and on the other hand, there are no people who are more likely to get catarrhal phthisis than those who have had their blood impoverished and their systems broken down by the malarial poison. In such persons an attack of catarrhal pneumonia is very apt to pass into a catarrhal phthisis. Therefore, where the fever is of a high grade and obstinate, it is well to consider the question of the possibility of the co-existence of malaria.

Now, what are the principles that should guide our treatment? I think we ought, as a rule, to try to get rid of this fever, even if it is only moderately severe; for certainly those patients who have the least fever do much better and live longer than those who have more marked fever.

The first thing we should do is to recognize the cause. Suppose we find a malarial element; this should be removed by full doses of quinia, and the patient kept upon the continued use of quinia and arsenic. I mention arsenic particularly, because you will find, in cases of obstinate hectic fever, arsenic a very valuable remedy; but to produce a good effect it must, in the first place, be well borne by the stomach, and generally the mucous membranes of patients with phthisis are very irritable, so that arsenic must be given with the greatest care; and secondly, if it is well borne, its use must be kept up for a long time. Under such conditions it is a very useful remedy. If, however, there is no trace of malarial complication to be found, but if the hectic fever assumes a distinct intermittent character, presenting, as I have said it sometimes does, a rigor, followed by high fever and marked sweating, so that it simulates an ordinary intermittent malarial fever, quinia is always to be given in large doses, and will nearly always modify the hectic fever, but will not stop it, as would be the case if a malarial element was present. To accomplish this full doses are required.

More frequently, however, we have a grade of hectic much less marked than this, one in which the morning temperature is not over 100°, and the evening 101° or 101.5°. Of course, this fever cannot be broken as long as active irritation is going on in the lung. We must, therefore, not expect such brilliant results from our remedies as we would in an idiopathic fever, and besides treating the febrile action, we must also address our remedies to the local catarrhal disease of the lung, by which the fever is kept up.

In these cases quinia is useful, but should not be given in such large doses as we would where a malarial element existed, that is, twelve or fifteen grains, but in doses of one or two grains, three times a day. As to the mode of giving this, I would be guided by the state of the circulation. If, at the same time, the pulse was rapid and weak, I should associate digitalis with the quinia. If, on the other hand, there was a marked tendency to night sweats and relaxation of the system, the fever not of high grade, and the pulse not rapid, I should use aromatic sulphuric acid with the quinia, and give them in solution. Nearly always, in these cases of fever, you will find a little opium an important addition to the quinia; for instance, there is no better combination where there is marked irritation, with fever of high grade, with rapid, weak pulse, than a pill of quinia, digitalis and opium; but you are to observe that this pill is to be used only occasionally, so that the patient will not be led into the habit of taking opium every day. I think there can be no doubt but that the habitual use of opium, except in exceedingly trifling amount, exerts a depressing effect upon nutrition. Of course, it would not injure the patient to take one-eighth or one sixth of a grain of opium, but to take as much as one-grain doses for a long time, I think is injurious; but, bad as opium is, there are things that are worse; for instance, a high degree of nervous irritation and hectic fever; so that, where we cannot dispense with opium, we must use it carefully. In such cases we may give one grain of quinia with one-fourth, one-third, or one-half a grain of powdered digitalis, and one-eighth, one-sixth, or even one-half a grain of powdered opium, three times a day, according to the indications of the case. Where there is a marked tendency to relaxation of the skin and to night sweats, one grain of quinia with ten drops of aromatic sulphuric acid and minute doses of morphia, may be given in solution, three times a day. I have already alluded to the use of arsenic where the hectic fever is obstinate, and a pill containing quinia, digitalis, opium and arsenious acid is often followed by an admirable result, if its use is kept up for a long time.

Lastly, you will often find that the hectic fever is kept up or increased by irritation of other mucous membranes, as the gastro-intestinal. Frequently after the catarrhal condition of the lung has been much relieved, the hectic fever will remain obstinate, and on a careful examination of the patient it will be found to depend upon a continuance of a catarrhal state of the gastro-intestinal mucous membrane, accompanied by a coated tongue, capricious appetite, impaired digestion, and other evidences of irritation of the digestive tract. Where such a con-

dition exists, we may be sure that any febrile action occurring at that time will be aggravated. In these cases, if we suspend all remedies directed to the lung, and treat with dietetic and regimenal measures and remedies, addressed to the digestive canal, we will obtain more relief for the patient than we did while treating the fever as a symptom of the lung trouble. All through the treatment of phthisis there is no principle so necessary as paying scrupulous attention to the digestive apparatus, not only because its irritation will increase the fever, but where a cure is effected, it is only brought about by a maintenance of the nutrition.

Let me now call attention to this patient, who was before us last week, and who illustrates in a marked degree the acute exacerbations of fever. He has a catarrhal phthisis of the upper right lobe, which, on the whole, has been slowly improving. At present, if you were to examine it, you would be surprised to find very few râles present. The respiration is somewhat feeble, and the expiration prolonged, but there are scarcely any râles. Now, with every change in the weather, or on some trifling exposure, so slight that, as yet, I have been unable to protect him from them, he will have a little creep, begin to feel dull, indisposed, and weak, and go to bed. His temperature, which may have been in the morning 99°, in the evening 99⅓°, will run up to 100.5°. The temperature has never been above 101°. Râles will be heard all over the lungs, coarse, sub-crepitant, passing into moist, mucous râles. After this condition has lasted for twenty-four, thirty-six, or seventy-two hours, he will begin to feel better, and will feel as well as usual until he has another attack of pulmonary catarrh.

Fortunately, in this man the catarrhal matter seems to have very little tendency to pass into a state of cheesy degeneration, and very little tendency to develop tubercles. In the course of the last four months I think he has had at least twenty of these attacks. As each of these passes away it leaves the lung in a little better condition than it was at the previous attack; so that, on the whole, there has been an upward tendency. This man has for a long time lived in this district, near the banks of the river, where he has been exposed to malaria. I suspect that he has, in connection with his lung trouble, a malarial taint. During the attacks he has been put to bed and treated actively, as I shall hereafter describe to you. He has also been put upon the continued use of quinia and arsenic, and I think that since he has been upon this treatment he has shown a decidedly less tendency to have these acute attacks.

At the last lecture I spoke of the occurrence of profuse night sweats. In the young man I had before me then, and who on entering had a sub-acute catarrhal pneumonia of the right apex, which passed pretty rapidly into softening, leaving a circumscribed cavity under the right clavicle, with a little solidification of the surrounding tissue, there was from the very first a degree of febrile action and profuseness of night sweats out of all proportion to the amount of local disease. He was treated by absolute confinement to bed, active counter-irritation over the affected spot, and full doses of quinia and chloride of ammonium. The congestion around the diseased spot began to clear up, no extension of the trouble occurred, and the general symptoms began to improve, but while the febrile temperature diminished, so that the evening temperature was not over 101°, he had drenching sweats every night.

Let us then consider this symptom of night sweats. Here, again, we find an individual element in the matter. Some, with comparatively little lung disease, and only a moderate elevation of evening temperature, will have copious night sweats, while others, with a considerable amount of lung trouble, and a high degree of fever, will have little or no night sweats. It is only when these sweats are extremely profuse that they are to be regarded as a bad sign. When they are only about as much as we would expect to have in order to carry off the febrile action, they are not unfavorable. It is better for a patient to have a fever which terminates in sweating, than to have a fever with a temperature of 103° going down to 101°, and the skin not becoming entirely relaxed and cool. Of course, the latter patient will be consumed much faster than the one in whom the fever is followed by sweating. In other words, the one has an intermittent, and the other a remittent fever, and the latter is much the worse. A moderate amount of night sweats is not, then, a bad sign.

Again, we are to remember that this is entirely secondary to the local disease of the lung and the febrile action; it is to be treated by treating the local condition and the condition of the other mucous membranes. It is only when it becomes a source of exhaustion that it demands a separate treatment. The remedies that do most good are those that increase the tone of the skin and act powerfully upon its blood-vessels.

Frequently you will find that the removal of the patient to a cool and bracing climate will

greatly lessen the night sweats. Sometimes they may be checked by a change of diet; a change to one consisting of light and easily digested food containing a large amount of liquid, which acts as a diuretic. Another useful measure is cool bathing, or cool sponge bathing with water containing salt or alcohol. This is a remedy that is too much neglected. It may be used much more frequently than is generally supposed, but the baths must be taken with care, going over the surface rapidly with the sponge, and immediately drying by friction with a towel. The temperature of the water must be regulated by the temperature of the body, never being so low as to cause chilling of the patient. This bathing is a most important element in strengthening the system and fortifying it against the repeated attacks of fever.

The drugs that are used to increase the tone of the skin are astringents, tannic and gallic acids, the mineral astringents, acetate of lead, sulphate of copper, oxide and sulphate of zinc. Frequently, you will find that while these remedies do good in one case, in another they will fail. Among the drugs that influence the state of the vessels, quinia and atropia may be mentioned as the two most potent. The quinia may be given in combination with any of the astringents I have mentioned, and is very useful where there is a moderate degree of fever with night sweats. Where the sweating is more profuse, you will find that atropia given at bedtime is a powerful remedy. It may be given in solution, in doses of one-hundredth to one-sixtieth of a grain, according to the susceptibility of the patient. This will produce a dryness of the skin, which will often enable the patient to pass through the night without his customary sweat; but I do not think that atropia is to be regarded as an adequate treatment for night sweats, since they depend not only upon the relaxation of skin, but are also due to the local trouble. I think it is well to keep up the continuous use of such remedies as the combination of quinia and tannic acid, or quinia with other astringents, while we reserve atropia for use at nights.

Sometimes the night sweats are checked by the external use of hot water containing alum or alcohol, which has a stimulating effect upon the skin, and thus tides the patient over his ordinary time for having the sweat.

In the patient I had before you at the last lecture I tried probably half a dozen of these remedies, without stopping the night sweats. Atropia had no effect. I then gave him a remedy whose use has lately been revived for the treatment of this condition, and one which I think is of little value, that is, agaric. I gave it to him in large doses, but it produced no effect. Finally, he began to improve under the use of quinia and tannic acid, but I attribute the cessation of the night sweats more to the subsidence of the local lung trouble than to the quinia and tannic acid, for as the lung became better the nutrition improved, and the night sweats became less marked.

Another symptom to which I alluded when we last met, and to which I again desire to call attention, is hemorrhage from the lung, and its significance. It presents itself under different conditions in these diseases. In the first place, sometimes a person who is apparently perfectly healthy, who has had no cough, will have spitting of blood, and after this evidence of lung disease shows itself. Secondly, sometimes at the very onset lung disease will be attended by marked hæmoptysis. Thirdly, during the course of chronic catarrhal phthisis the fresh attacks of increased catarrhal irritation and congestion are often associated with spitting of blood. Fourthly, where destructive disease of the lung, with the formation of a cavity, has occurred, some of the vessels may be opened and give rise to profuse hemorrhage.

We are to consider hæmoptysis under these four heads: First, as to its significance when occurring without any previous signs of lung disease in those who are in apparent health. We have here a patient who well illustrates this condition. He has a catarrhal phthisis of the upper portion of the left lung, and a cavity in the upper lobe, with some scattered centres of solidification and cheesy softening in its neighborhood. His history is, that seven years ago, while sitting upon the steps in front of his house, he suddenly had a profuse hemorrhage. The amount of blood is often exaggerated by the patient. It is usually about three or four ounces. At that time he had no cough or fever, and for two years he continued well; he then began to have catarrhal disease, which has gone through the very chronic course of catarrhal phthisis.

It has been customary to say that such a hemorrhage is an indication of the deposit of tubercle, but this is not the case in the majority of instances. I have already told you that the growth of a tubercle is a process of obliteration of vessels. We may safely say that hæmoptysis, whatever else it means, is not a common sign of the formation of tubercles. Now, where we have a hemorrhage, as in this case, coming on in a healthy person, with no fever, no cough, and no

evidence of lung trouble, we can hardly think it possible that such a hemorrhage has come from the air cells. I have no doubt but that this came from the large tubes, that it was all expectorated, and that it was not connected with any disease of the lung tissue proper.

Again, you will sometimes find that after a hemorrhage the patient, instead of getting perfectly well, presents a little cough and other lung symptoms, which afterward turn out to be those of catarrhal disease. Now, there are two explanations of these cases. Either the patient had an acute congestion of the lung and a certain amount of catarrhal pneumonia, and the hemorrhage was due to congestion of the lung, or else the blood that was effused was not all expectorated, but some was drawn into the vesicles by the gasping efforts during the hemorrhage and there coagulated, and remained as an inert dead body, subject to decomposition. This excited irritation and caused the local catarrhal process. It is exceedingly difficult, in some cases, to say what has been the exact order. In reading, you will find that some authorities are disposed to take the first view, and others the second view; but certainly both of these may occur. My own opinion is that in the majority of cases where hemorrhage is followed by evidences of irritation of the lung, catarrhal pneumonia, catarrhal phthisis, there has been at the time of the hemorrhage a congestion, or a catarrhal pneumonia of the lung, and only in comparatively rare cases does the blood set up any catarrhal disease of the lung. I have seen so many cases of hemorrhage from the lung in heart disease, and no pulmonary trouble follow, that I am sure that in many instances hæmoptysis does not set on foot catarrhal pneumonia. From what I have said, you will see that hemorrhage from the lung is not to be regarded, necessarily, as a symptom of phthisis; but undoubtedly, the fact that a patient has had hæmoptysis is an evidence of weakness of tissue, an evidence of want of tone of the vessel wall, and therefore indicates that probably the vital processes of that lung are not of a high grade, and would not tend to a rapid restoration to health if that lung became diseased. Such hemorrhage is therefore an unfavorable sign.

Frequently, during the course of chronic catarrhal phthisis, hemorrhage occurs, and this usually marks the occurrence of fresh attacks of catarrhal pneumonia or congestion. Nearly always after the hemorrhage has passed away the physical signs will show that there has been some extension of the disease around the affected spot. The blood comes far more from the surrounding healthy tissue than it does from the diseased part. One of the most serious troubles in this disease is that the blood vessels in the affected part become obstructed, the nutrition is impaired, and this leads to a rapid degeneration of the diseased part.

The hemorrhage that occurs in either of these three ways is not usually dangerous, and does not seriously weaken the patient. When a patient has had a chill, followed by congestion of the lung, which must relieve itself in some way, it is better that hemorrhage should occur and be expectorated, than that the congestion should relieve itself by an effusion into the air vesicles. What we are to dread is not the amount of blood lost, but the fact that it is usually an indication that a fresh portion of the lung has been involved in the destructive process.

Lastly, after the disease has lasted some time, and there has been destruction of the lung tissue, with the formation of a cavity, a frightful hemorrhage may occur, and the patient may be smothered in a few moments. Examination has shown that the blood vessels ramifying in the walls of a cavity are apt to form small aneurisms projecting toward the cavity. These are attended with thinning of the blood vessel wall and liability to rupture, causing severe hemorrhage. Again, this hemorrhage may be produced by the ulceration involving and cutting the walls of a blood vessel.

Our treatment of hæmoptysis will depend upon what we determine to be the source of the hemorrhage. If we had a patient like this last one, in whom it occurred without any symptom of lung trouble, and on examination with the laryngoscope we find no ulceration of the trachea, for sometimes by this means we are able to detect the exact seat of the hemorrhage, I say, if we find no physical signs of disease of the lung and no ulceration, we must locate the seat of hemorrhage in the large bronchial tubes, and a great many of these hemorrhages are due to congestion of these tubes, or to minute ulcers on their walls.

I must postpone the further consideration of the treatment of hæmoptysis until we again meet.

Signs of Death

We learn from the *British Medical Journal* that M. Beyraud, of Libourne, in a communication to the Academy of Sciences in Paris, writes that real death may be recognized in a practical manner by means of the application of the cautery to the supposed corpse. If the eschar do not show itself, the subject is dead; if it be yellow and transparent, the subject is dead; if it be black or of a reddish-brown, the subject is living.

Communications.

HOW TO MAKE A CHEAP GALVANIC BATTERY.

BY WM. R. D. BLACKWOOD, M.D.,
Of Philadelphia.

Two years ago, in a continued paper illustrating the advantages of electricity in the cure of disease, a promise was made to give at some future time directions for making a galvanic battery at a low cost, and since then I have received letters from almost every State and Territory, asking me to write the promised article, but time has been wanting in which to do it: and now I must claim indulgence, as this article is written at odd moments, which, as every author knows, is a bad way to do such work.

The idea is commonly held that a battery, to be good, must be purchased at a high cost, and is necessarily of superior finish; but the notion is eroneous. None of my batteries—and I have seven, from as many different makers—give me better results, or are more easily kept in order than that which I made myself. Another mistake is, that galvanic cells must be necessarily large, such as are found in telegraph offices, or cabinet batteries; but no better work is obtained through such cells than by means of the small and compact cells of portable batteries, which are now widely used, but which are with difficulty maintained in good condition, owing to their complexity. The battery now to be described is not portable, so far as carrying in a carriage is concerned, but it can be taken from place to place, by handles attached to the box, if carefully managed; and as nearly all electrical treatment is made in the physician's office, portability is not essential.

Without further preliminary remarks let us commence our task. We require 100 one-ounce quinine bottles; 100 pieces of stout glass tubing, three-fourths of an inch in diameter and 5½ inches long; 100 pieces of sheet copper, 2 inches wide by 4 inches long; 100 pieces of sheet zinc, 2 inches wide by 4 inches long; 300 patent gun-wads, accurately fitting the glass tubing; 100 feet of soft copper wire, No. 18; 100 McGill's round-headed paper fasteners, No. 3; a box to contain the battery, in which the cells fit snugly enough without movement laterally, but from which they can be lifted vertically, one at a time, for examination or repair. Handles of any kind may be attached to the box.

The above eight articles are readily obtainable—the quinine bottles from any druggist; the tubing from druggists, or dealers in glass ware; the copper from dealers in metal; the zinc from stove merchants (but rod zinc, when obtainable, is better, for durability); the gun-wads from hardware stores, or dealers in powder and shot; the copper wire and tacks at hardware stores; the paper-fasteners at any stationer's; and a soap or starch box, cut down so as to nicely fit the cells, can be got from the grocers' shop. The cells may be arranged in twenty rows of five wide, or ten of ten wide, which is the better plan. The cells should come up to about an inch from the top edge of the box, and the glass tubes project half an inch or so from the top of the cells. Having first fitted the quinine bottles into the box securely, stop one end of each glass tube with three of the gun-wads, and place a tube thus prepared inside each quinine bottle. We now have our cell complete, the quinine bottle forming the outer or main cell, and the tube being the porous, or inner cell. Next, cut the copper and zinc into strips, 2x4, as directed, with tinsmith's shears. Each piece of copper and zinc has next a strip cut along one of the long (4 inch) sides, a quarter of an inch wide, up to half an inch from the end, and this strip is bent upward and doubled upon itself over the half inch remaining uncut, thus forming a prolongation of the plate, and is intended for making the connection between the elements. *Be careful not to cut this narrow strip completely off the plate*—it must be an integral part of the metal, and when bent up, as directed, the plates are 1¾ inches wide at the bottom, with this strip, 3½ inches long, continued from one of the upper corners, making the entire length 7½ inches. The diagram illustrates the shape of the plate when finished. The copper plates must be bent into the segment of a circle so as to fit loosely in the bottle, or outer cell, and the zinc rolled up so as to easily go into the tube or porous cell. Now put a copper into each cell, where it will partially surround the tube, and a zinc into each tube. Having done this, bend the narrow strips which project upward from the cells at a right angle, about an inch and a half from their end, and this should be done accurately to insure good connection. Next coil a sufficient length of the copper wire over any flat object a quarter of an inch wide—and a corset steel is exactly the thing—and cut this flat coil of wire into pieces an inch long. These pieces of coiled wire are slipped over the ends of the copper and zinc plates (at the point indicated by the * on the diagram), and serve to bind the connection firmly and make good contact.

Having joined the copper and zinc together by slipping them into the flat coils, push one of the paper fasteners into the binding coil, and it, acting as a wedge, makes the joint tight. Now comes an important matter as to connections. Let the cell in any selected corner be designated No. 1; the *zinc* of this cell is joined to the *copper* of cell No. 2, then the *zinc* of No. 2 to the *copper* of No. 3, and so on until the *zinc* of No. 99 joins the *copper* of No. 100, when the circuit will be complete. The zinc and copper of any individual cell must never touch each other. We have now the copper of No 1 free, and this is fastened by a coil of wire to the side of the box, one end of the wire being coiled *flatly* on the copper strip, and the other end coiled in a *round* form and tacked fast to the box with a copper tack. Into this round coil a pin on one end of the conducting cord can be inserted when using the battery, and this is the positive pole, or anode. At the other terminal we have the zinc free, which is secured in the same manner to the box, and forms the negative pole or cathode. The current enters the battery at the anode and leaves it at the cathode when in action, and, of course, passes through anything interposed in the circuit; as, for instance, a sensitive young lady under treatment for neuralgia, or an inanimate galvanometer, if you are testing its electro-motive force. We do not, however, always want the entire battery power, and, therefore, a wire is fastened in the connection between every five or ten cells, and tacked to the side of the box, precisely as in the case of the terminals. With your conducting cord in, say the anode, or No. 1, you may peg the other into No. 15, 25, 60, 85, or any other desired selector, as these are called, according to the power needed. These selectors should be fastened to the end cell of a row, and the wire must not touch any connection other than the one intended.

Your battery will not work without solutions, and of these many different combinations are available. During the past two years I have carefully tested a large number of combinations, and measured their electro-motive power, but a few examples only will suffice.

No. 1. A saturated solution of sulphate of copper for the outer cell, and a saturated solution of sulphate of magnesia for the tube or porous cell. For the magnesian sulphate you may substitute zinc sulphate or dilute sulphuric acid, one part acid to twelve of water.

No. 2. Chloride of copper for outer cell, and chloride of ammonium, zinc, or sodium for the tube or porous cell.

No. 3. Remove the gun wads, leaving the glass tubes open, and fill with a saturated solution of sodium chloride, to which is added a drachm of aqua ammonia for each cell. This forms a single solution element, and although not so constant as the differential solution cells, for more than a few hours of continuous service, it will suffice excellently for moderate daily use, and is easily managed. After a couple of hours' rest the battery regains its full strength. Whatever solutions are used, water must be added every week, or so, to make up the evaporation. Crystallized salts also must be removed as they form on the edges of the cells. It is useless to coat the mouth of the cells with wax, stearine, etc., to obviate the running over of crystals; keep an eye on your battery, and keep it well filled and clean.

I made my last battery, as above described, two years ago. It took three hours' work, each of two afternoons, to complete it, and cost $8.30, the quinine bottles costing nothing. As the zincs wear out, they are shifted toward the cathode, new ones being added at the anode, the point of greatest destruction. Sixty new zincs were required since, the coppers still being as good as new. The tubes must be examined frequently, to see that the wads do not come out; if they do the electro-motive force of the battery is partially or wholly destroyed beyond the break. The power is dependent on the weakest cell, as on each link of a chain. Metallic copper from the sulphate will be deposited on the porous wads after a time, and it must be carefully removed without breaking the tubes. Put in new wads when the old ones get too soft. Some of mine are yet in, after an average use of eighteen hours per week of the battery. Aside from the zincs and experiments with differential solutions, my battery has not cost me one cent for repair. This battery is available for extended experimental purposes, and can be made a source of infinite pleasure and improvement to the student of electricity.

Pliable conducting cords, armed at one end with a wire or brass peg, for insertion into the selectors (or round coils) at the side of the box, and at the other with rheophores, or instruments for properly applying the current to various parts of the body, must, of course, be procured at any electrical depot. A few appliances only are really needed, and nine tenths of the long list of special electrodes illustrating price lists are superfluous; they are made to sell. Most electrodes can be home-made, and will serve every purpose. It is not the armament of instruments

that make the successful practitioner; it is the ability to use a few in the right way. I have more than a hundred electrodes which were purchased at meetings of the American Medical Association, and at such like times, when manufacturers pounce on physicians known or suspected to be interested in electro-therapeutics, or such as were presented by grateful patients (and there are some now and then), but in common daily practice I use, probably, half a dozen only. There are many little points in the management of electrical apparatus, and in the department of electro-therapeutics, which, being foreign to the present paper, must be deferred "to a more convenient season." Trusting the description will be clearly understood, I can assure those who possess mechanical skill enough to follow it—and a little only is needed—that they will have a battery in every way the equal, and in many respects the superior, of much more pretentious machines; one with which much good may be done by intelligent employment, and which will "put money in thy purse," a point not to be despised in this practical world.

246 *North Twentieth Street.*

OBSTETRICS IN THE EIGHTEENTH CENTURY.

BY M. O. LOWER, M.D.,

Of North Manchester, Indiana.

Obstetricians in the eighteenth century differed but very little from those of the present day, except in theory. Turning and the use of the forceps, crochet, etc., was about the same, with a few exceptions, as it now is. There were not so many different presentations of the fœtus recognized as there are at this time. The secretion of the uterine mucous membrane was thought then to be for the purpose of lubricating the cavity and canal of the neck, so as to prevent the sides from coalescing or growing together, and during the time of gestation these glands were supposed to secrete a mucus for the nourishment of the fœtus during the whole time of fœtal life; the placenta and membranes were thought to be covered by a cribriform or cellular substance, and it adhered by contact only to the mucous membranes of the uterus, and absorbed the mucus that was secreted by the above-mentioned glands and carried it to the fœtus, for its nourishment. These glands, then, were called the colatura lactea. Of conception, it was thought that during the orgasm of coition the male seed was thrown into the uterus, and thence conveyed into the cavity of the Fallopian tubes, by some absorbing or convulsive power, the fimbria at the same time grasping the ripened ovum; a few seconds only elapsing from the time of emission of the semen until impregnation of the ovum took place, *i. e.* if coition occurred immediately after the evacuation of the menses. It was thought that when the semen and ovum thus mingled, one of the animalculæ insinuated itself into the ovum, and joined with its belly to that ruptured part of it, from which the naval string is produced, or entering one of the vessels, is protruded to the end of the funis, by which a circulation is carried on from the embryo to the placenta and membranes. The then impregnated ovum was supposed to be endowed with a circulating force by the animalculum, by which means it found its way into the uterus. It seems as though the umbilical vein was thought to be formed before the ovum left the ovary, and in its passage through the Fallopian tube the embryo was nourished by the secretion formed therein, which was thought to be taken up by the umbilical vein and carried to the impregnated mass. The blocking up of the cervix during gestation was thought to be caused by some of the semen being mixed with the fluid secreted by the glands contained in the cervix. In the early part of gestation it was the belief that the ovum swam in a fluid which it absorbed, to increase gradually in magnitude, until it came in contact with all the inner surface of the fundus of the uterus. At that time there was no other term for a premature expulsion of the embryo or fœtus than a miscarriage, even if it happened at any time from conception to within a few days of the natural time of labor. Of moles there was but one kind known, and they were thought to be caused by the death of the embryo and its dissolution, so that at the time of its discharge nothing appeared but the secundines. The serum in which the child swims was thought to be furnished by lymphatic vessels opening into the inner surface of the amnion.

The allantois, it was the impression, contained the urine of the fœtus, but it had not yet been certainly discovered in the human fœtus; it was the opinion of most of the authors then, that the fœtus was nourished by the absorption of the nutritive fluid into the vessels of the placenta and chorion. The blood that supplies it was presumed to circulate in full stream from the arteries of the uterus to the veins of the placenta and returned by the arteries of the las to the veins of the first, to be refined and made arterial blood in the lungs of the mother. Vomiting in preg-

nancy was thought to be servicable to the patient by unloading the stomach of superfluous nourishment, thereby carrying off, or preventing too great a turgency in the vessels of the viscera and uterus, and by creating a kind of straining or nisus in the parts, which was supposed to assist the fundus and neck of the womb in stretching. The cause of this vomiting was supposed to be from the uterus being stretched by the increase of the ovum, and causing tension of the parts, affecting the nerves of the viscus that arise from what was then called the sympathetici maximi, and communicate with the plexus at the mouth of the stomach. Of the position of the child in the uterus, it was the idea of many that its head was turned up to the fundus and its breech to the os-uteri, with the fore parts toward the mother's belly, and that it remained in that position until labor began, when the head came downward and the face turned to the back of the mother. Some alleged that the head precipitated about the end of the eighth or beginning of the ninth month, by becoming specifically heavier than the rest of the body. Others affirmed that the child increased in bulk, especially during the two last months, and the proportion of surrounding water was diminished, so that it was confined in its motion, and in struggling to alter its position the head was moved to the os-tincæ where it remained until delivery.

Smellie thought that the head was for the most part turned down to the lower part of the uterus, from conception to delivery, but he was not very strong in his opinion, as he says it is open to objections.

At the time of birth, when the placenta was delivered immediately or soon after the child, by the continuance of labor pains, or when it became necessary for the accoucheur to extract it before ligating the cord, so as to restrain too much flooding, if the child had not breathed yet, and there was the slightest pulsation in the vessels, it was the teaching to throw the placenta and as much of the navel-string as possible into a basin of warm wine or water, in order to promote the circulation between the placenta and child. Some advised to lay the placenta on the child's belly and cover it with a warm cloth; while others ordered it to be thrown upon hot ashes. When the labor was tedious and it became necessary for the obstetrican to assist nature in her efforts, the fillet was usually made use of, of which there were several kinds. The kind commonly used was made in the form of a sheath, mounted upon a piece of slender whalebone, about two feet in length, which was applied in the following manner: If the orifice of the vagina and the os-uteri were not sufficiently open they were gradually dilated as much as possible by the hand, which was at the same time introduced and passed along the side of the head, in order to ascertain the position. This being known, the other hand introduced the double of the whalebone and fillet over the face and chin, where the best purchase was had, and where it was the least likely to slip loose its hold. After this application was effected the operator's hand was brought down, and the whalebone drawn from the sheath of the fillet, which, after the ends were tied together, was pulled during every pain, pressing at the same time with the other hand on the opposite part of the head. The forceps, too, which were then covered with leather, were sometimes used, but the fillet more frequently. Some of the authors describe the method of extracting the head when left in the uterus, by means of a net, but as it was applied with great difficulty, and they could not succeed very well with it when the head was too large or the pelvis too narrow, it was abandoned. Sometimes, when the head was too large, or the pelvis too small, and it became evident that it must be extracted by force, an instrument that was termed the "speculum matricis" was used to stretch the pelvic bones asunder and give greater capacity in the pelvic basin. If this means failed, many others were used that seem equally as absurd. When post-partum hemorrhage occurred after the birth of the child, it was treated by dipping cloths in cold, astringent fluids, and applying them over the abdomen, and venesection, and by ligatures compressing the returning veins at the hams, arms and neck; and besides this, the vagina was filled with tow, or linen rags dipped in a solution of oxycrate or red tart wine, in which a little alum was dissolved. If the patient had a natural labor, the after-treatment was then about the same as it is to-day, except small additions that have been augmented.

Curtains or No Curtains.

The Commission charged with the arrangements relating to the new Maternity Hospital in the Rue d'Assas, at Paris, are greatly exercised as to whether there should be curtains to the beds or not. Some of the most eminent French obstetricians are in favor of them, others are totally opposed to their presence. The conclusion arrived at seems to be that those physicians who like curtains will have them to their beds, and those who do not will dispense with them.

Hospital Reports.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

CLINICAL LECTURE, MAY 5, 1880, BY WILLIAM GOODELL, M.D.,

Professor of Clinical Gynæcology in the University of Pennsylvania.

REPORTED BY WILLIAM H. MORRISON, M.D.

Enlargement of the Abdomen.

GENTLEMEN:—Here is a case of enlargement of the abdomen; I have not yet examined it, but this is the history: She is a colored woman, forty-seven years old. Has had five children, the youngest of which is twelve years old. A year ago she noticed an enlargement of the abdomen, which has rapidly increased in size. Her menses were regular up to last February, when they ceased. She has emaciated rapidly and has œdema of the legs. She measures 47½ inches around the body at the umbilicus.

Now, gentlemen, for the last few weeks I have had under my care, with a most intelligent physician, a case which I examined with the utmost care and diagnosed to be a fibro-cystic tumor, and the attendant physician's opinion inclined to mine; but the emaciation was so rapid and so great, that we thought it must be malignant. I examined the tumor carefully last week, but could not positively detect fluid; there was elasticity, but no fluctuation. I plunged in an aspirating needle, and as soon as I saw the fluid I said, "this must be ovarian." I took some of it to Dr. Formad, and he found the ovarian cells. I operated last Sunday. The difficulties of the operation were very great, and at first I thought that Dr. Formad must have made a mistake. I opened one cyst and then there was another. I opened that, and a stream of blood as large as my little finger leaked out. I had to plug the opening up and proceed as rapidly as possible to remove the tumor, which was very adherent. It proved to be a cyst of the left ovary, but as the right ovary was also diseased, I removed them both. Here the diagnosis was settled by the microscope. The woman is doing very well.

Here comes a colored woman with the statement that she noticed a tumor about a year ago. Now, here is one difficulty; ovarian tumors are extremely rare in colored women, but fibro-cystic tumors are quite common. A fibro-cystic tumor is a fibroid tumor which takes on cystic degeneration, and one or several cysts enlarge rapidly. There is no possible way of making the diagnosis from the external signs.

Mr. Spencer Wells, who has operated over one thousand times, when in this country, examined a colored woman, with an enlargement of the abdomen and pronounced it to be an ovarian tumor. Dr. Washington Atlee, who had operated some three or four hundred times, was present, went up to Mr. Wells and said that it was extremely rare for an ovarian tumor to be found in a colored woman, and asked him to examine the woman again. He did so, and with Dr. Atlee's help, came to the conclusion that it was a fibro-cystic tumor, as it afterward proved to be. I have never yet seen an ovarian tumor in a colored woman.

There is very evident fluctuation here, but you may have fluctuation with a colloid tumor, and you may tap and get no fluid. I do not think that this is colloid. This fluid may be in the peritoneal cavity, but one thing that makes me think it is not peritoneal is that it looks so like pregnancy, prominent in front. In peritoneal dropsy there is bulging at the side.

Let us examine by percussion. There is complete dullness in front; but with a peritoneal effusion of this size the intestines may be held so far back that we may have dullness in front. In the flanks the note is not quite so flat but there is no resonance on either side.

I am sure that there is fluid here, and I wish to tap her to-day. I shall show you how to tap painlessly. I take a piece of ice, put some salt on it, and press it against the skin, thus freezing the skin at the point of puncture. I shall make the puncture in the median line between the umbilicus and the pubes. I wish to have some of this fluid for microscopical examination, for if this is a fibro-cystic tumor, there will be great difficulty attending the operation, and in such cases the womb usually has to be also removed.

What was the significance of the cessation of the menses? This looks very much like ovarian disease; as though both ovaries were involved; but this does not go for much, for the woman from whom I removed both ovaries last Sunday menstruated regularly, although both ovaries were diseased.

I plunge the aspirator in, but I do not get a particle of fluid. You see here the difficulty of diagnosis. I said that I thought this was not colloid, but from its non-appearance I am disposed to think that it is colloid. There comes a little. You see how thick it is? It is colloid; in other words, like jelly. This leads me to think that this is an ovarian tumor; but Mr. Spencer Wells opened the abdomen to remove an ovarian tumor but found it to be a colloid tumor of the abdomen, arising from some tumor of the mesentery.

I shall have to perform the operation just as soon as she can submit to it. I shall have this fluid examined, and shall await with intense interest the result. If there are no ovarian cells I shall undertake the operation with misgivings.

Are there any dangers from this little operation of aspiration? There are dangers. There was a time when I tapped very frequently, but as I have grown older I have learned some lessons. The lady whom I tapped last week was seized with a severe pain in the right side after the operation, and a peritonitis set in, but under the judicious treatment of her physician it was controlled. As soon as I opened the abdomen on Sunday, out came a quantity of bloody-looking water. Examining the cavity of the abdomen, I found a number of clots which had resulted from the operation. I believe that they occurred in the following way: As soon as the tumor began to contract, from the loss of fluid, there were adhesions on the right side which broke, and from this there was oozing of blood. In operating once for a fibro-cystic tumor I tapped one of the cysts, but the hemor-

rhage was so great that I had to plug the opening before I could go on with the operation.

If you use the trocar for tapping, the operation should always be done under the spray, but if you use the aspirator, there is very little danger of contaminating the contents of the cyst. Tapping an ovarian, or any other of these cysts, is a serious operation.

From the color of this fluid I presume that we shall have an ovarian cyst of a mottled character, looking very much like mottled jelly. These cysts usually have very thin walls. Dr. Baer will remember a case upon which we were operating in the country, in which the cyst wall was so thin that it broke, but the contents were so thick that we scooped them out with our hands, not a particle of it getting into the abdominal cavity. This cyst weighed forty five pounds. The woman recovered without a bad symptom, or, as her physician wrote to me, "without a ripple of trouble."

As I remove the needle I press the skin down over the opening and apply a piece of adhesive plaster.

I regret not being able to empty this cyst, for several reasons; first, because I am pretty sure that, small as this opening has been, the cyst being so dense and tense, a small portion of the contents has escaped into the peritoneal cavity. While perhaps it is true that the acridity of the fluid of these cysts has been overrated, yet there is no doubt that the peritoneum resents these fluids, and their presence may cause peritonitis.

Secondly, had I been able to empty this cyst, I should have been able to take a few weeks, before operating, to build up the woman's health and strength by giving her iron and quinia.

Thirdly, I should have diminished the length of my incision, and have diminished the size of the blood vessels; just as when you make a hole in a piece of rubber, the hole increases in size as you stretch the rubber, and diminishes as it contracts. Now, if I could have reduced this tumor to one-third of its present size, I should have greatly lessened the size of the incisions, and the blood vessels would have been contracted, and thus the danger of hemorrhage be diminished.

Recto-Vulval Fistula.

Here is a case, fortunately rare, because it is exceedingly hard to cure. It is one of recto-vulval fistula. Its existence has been denied by some physicians, but here is a case in point. It has annoyed her a great deal. When she came into the hospital I asked Dr. Sheppard to inject a saturated tincture of iodine into the fistula, hoping that it might reach all parts of the tract, set up adhesive inflammation and thus cure it. It has done good, but has not resulted in a cure. Now, in man, who has no vulva, you can make an incision, laying the fistula open, and allow the parts to heal from the bottom; but if in woman we should make an incision into the vulva, we should have artificial lacerated perineum, which would not heal. We must therefore try to heal this in some other way. Another way would be to cut through the parts with an elastic string, allowing the parts to heal up as it cut through.

I have now passed the sound from the vulva to the rectum. Now comes the question as to what is to be done. The temptation is very great to make an incision, laying this open. I should like to do so, but there is danger that an opening would be left which would not heal. I had thought of using nitric acid, but on second thought I think the best plan would be to cut down as far as the sphincter and then use the elastic ligature. I find that I can get to one side of the vulva.

I fasten a string to the end of the sound and thus draw the ligature through. This fistula has been the result of a small abscess. I think that this is the first one I have ever seen in the vulva. I have seen them before in the vagina. I now cut down with the scalpel until I see the fibre of the sphincter. I had thought of nicking the skin before tying the ligature, but shall not do so, because I want the internal portion to be cut through first. As a piece of good luck, I am able to get to one side of the vulva, and we shall have more or less union resulting.

She has come a long distance to have this operation performed. Her principal reasons have been because it makes her repulsive to her husband, and she breaks wind through this opening. Otherwise, she experiences very little trouble from it. Since the injection of the iodine she has had very little discharge from it.

The existence of recto-vulval fistula is denied by some gynæcologists. I do not see why it does not occur more frequently, because abscesses in this position are quite common. We have recto-vaginal fistula by no means uncommonly.

I shall have a suppository of opium (gr. j, of the aqueous extract) put into the bowel at once, to relieve the brunt of the first pain when she comes out of the ether, for the ligature will be quite painful.

What should you do when you have an abscess in the vulva or vagina? Suppose an abscess in the vulva; where should you open it and when? Open it as soon as you are satisfied that pus is present, and on the mucous surface always, because there the opening will heal up and leave but a small scar, while if it is opened at the cutaneous surface, there will always remain a marked scar. Open it freely and you need not fear hemorrhage, because you know you can always control it by means of a sponge.

One word in regard to styptics. I used to employ Monsel's solution quite frequently, but now I resort to it only when forced to do so. It is an exceedingly dirty application. It contracts all the parts with which it comes in contact. It also forms firm clots, as firm as plaster-of-Paris, which require time to break down, and when they do break down, do so with an offensive odor, and are apt to produce septicæmia. In my opinion it should be used in post-partum hemorrhage only as a last resort, after everything else has failed. If you use Monsel's solution on the vagina, you will not be able to introduce your finger after the application. Suppose you are operating for a carcinoma of the cervix and you apply Monsel's solution to control the hemorrhage, the parts will be so contracted that you cannot introduce your finger unless you give ether. Of late, I have been using vinegar as a styptic in the removal of tumors, and find it answers very well.

Result of Operation for Laceration of the Cervix.

I next show you the result of the operation for laceration of the cervix, performed two weeks ago to-day. You see there is nothing left of that red and ulcerated cervix. The operation has been wholly successful. This woman has a retroversion, which, after a while, will have to be attended to by a pessary. In the course of a few weeks these lines left by the sutures will have disappeared. This was my sixty seventh operation for laceration of the cervix. Since then I have operated three times.

Vesico-Vaginal Fistula—Closure of the Vulva.

The next case is a very pitiable one. It is the case of a colored woman who has had a very hard labor, which left her with a vesico vaginal fistula. She came to me and I found that there had been such destruction of tissue that it would be impossible to restore the bladder; so I attempted to close up the vulva, leaving the urethra, which was intact, and making the vagina a supplemental bladder. I succeeded only partially, and sent her to the country to recuperate her strength. The union was perfect everywhere except just under the symphysis.

It is humiliating to the surgeon to have to resort to this operation. It is an acknowledgment of defeat, and it destroys one of the woman's functions as a wife; and further, there is more or less trouble from an operation of this kind. The vagina is not intended as a receptacle for urine, and excoriations occur. We also have deposits of urinary salts and the formation of calculi, which begin to ulcerate their way through.

This operation of closing the vulva and leaving the urethra is the only one that I have attempted. In the other cases that I have operated on the urethra had disappeared. In one there was a vesico-vaginal fistula. I made a recto-vaginal fistula by means of the hot iron, and after this opening had formed I closed the vulva, making the rectum a supplemental bladder. Finally there was so great a tolerance that she could hold her water for several hours. The other was in an unfortunate girl, who, unmarried, got into the family way, and during parturition the family tried to keep it a secret and did not send for a physician in time. The result was a recto-vaginal and a vesico-vaginal fistula. In her case I closed up the vulva. She is now working in a mill down town. I saw her a short time ago and she is doing very well.

In this case I closed up the vulva and left the urethra open. The operation was not successful, because directly under the pubes there is very little tissue, and at that point the union failed. I shall not have time to operate to-day. The parts have become so thickened and hardened, from the constant trickling of the urine over them, that it will be a difficult operation.

I will get the history of the case. She is twenty-two years old, and has had one child, sixteen months ago. She was taken in labor on Sunday at 7 P.M. The child was born on Thursday at noon. Now, gentlemen, with your teachings you would not have left the case run on for that length of time. If you could not have carried the case through yourself, you would have sent for a brother physician to share the responsibility with you. The forceps were applied on Tuesday, again on Wednesday, and the child was born on Thursday. On Tuesday the head was not in the cavity; the forceps were applied, the head brought into the cavity and allowed to remain. This was right, in one sense, but it was left too long.

I shall send the woman out, for I do not wish her to draw an inference from what I say; for when a man does as well as he can, according to his light, he should not be blamed by his conscience or by any one else. I had an uncle by marriage, who lived to be ninety years old, who never owned a pair of forceps, nor do I think he ever performed craniotomy, at least, never more than once. You can imagine how long some of his cases were in labor. He relied, as a witty Frenchman has said, on "plenty of lard and more patience."

This accident, as a rule, does not occur in a small pelvis, because in such cases the head cannot get into the cavity. This pelvis is small, but the head was drawn into the cavity by the forceps on Tuesday, and left to mould itself, which is often a very good way. It is a good plan, if after trying to deliver with the forceps, you cannot get the head down, to go away for a couple of hours and allow the head to become moulded; but here it was left too long. The physician tried again on Wednesday, and failed; he then sent for another physician. He should have sent on Tuesday, when he found that he could not deliver the head.

What would have been more proper would have been to have performed craniotomy on Tuesday; but this is an operation looked upon by every one with the utmost horror. There are some who, from a religious point of view, object to the performance of craniotomy while the child is alive. I have a medical friend in this city who will not perform craniotomy while the child is alive. From a religious standpoint he is right, but from a humanitarian standpoint he is wrong.

The forceps should, as a rule, be applied early. You are young; you put the forceps on and pull for an hour or two; you get tired out, you get demoralized, as I do to this day; you know that you are pulling a living head through living tissue, and the thought brings the sweat out on you; and then you are not pulling as you would pull a nail out of a board, bracing your feet and pulling with all your might, but you are only pulling with the strength in your arms, from your shoulder down, and, as I say, you get tired out and demoralized. Now, in this condition of affairs, I advise you to do one of two things; either take off the forceps and go away for an hour or two, then come back and try again, and, in the majority of cases, the head will be delivered easily. Failing in this, send for a brother practitioner, for if a vesico-vagina fistula occurs, there will be two to bear the blame; for these accidents have given rise to lawsuits, and physicians have had to pay largely for a vesico-vaginal fistula, I think wrongfully; but you can always get out of the scrape by having another man with you; for it is not so easy to convict two as one.

Don't be in a hurry after you get the forceps on, but take plenty of time.

Editorial Department.

Periscope.

Glycerine in the Treatment of Flatulence, Acidity, and Pyrosis.

Drs. Sydney Ringer and William Murrel write, in the *Lancet*, for July 3, 1880:—

An old gentleman, who for many years suffered from distressing acidity, read in a daily paper that glycerine added to milk prevents it turning sour, and he reasoned thus: "If glycerine prevents milk turning sour, why should it not prevent me turning sour?" and he resolved to try the efficacy of glycerine for his acidity. The success of his experiment was complete, and whenever tormented by his old malady he cures himself by a recourse to glycerine. Indeed, he can now take articles of food from which he was previously compelled to abstain, provided always that he takes a drachm of glycerine immediately before, with, or directly after his food. He recommended this treatment to many of his friends—sufferers like himself—and one of these mentioned the above circumstances to us.

We have since largely employed glycerine, and find it not only very useful in acidity, but also in flatulence and pyrosis, and that it sometimes relieves pain. We meet with cases where flatulence, or acidity, or pyrosis is the only symptom, but more frequently these symptoms are combined. Some patients rift up huge quantities of wind without any other symptoms than depression of spirits; in others we get flatulence and acidity, one or the other predominating; and we meet with others who suffer from acidity, and also pyrosis. In all these various forms we find glycerine useful, and in the great majority of cases very useful. We do not mean to say that in all cases it is superior to other remedies for these complaints; indeed, in several instances it has only partially succeeded, where other remedies at once cured. On the other hand, in some cases glycerine speedily and completely succeeded, where the commonly used remedies for acidity and flatulence completely failed. We do not pretend to estimate its relative value to other remedies; we are only anxious to draw attention to its virtues.

Gas is in some instances formed in the stomach, in others in the large intestine, in some patients in both. Our observations were made on stomach flatulence, and as glycerine is so readily absorbed we should hardly expect that it would influence the formation of wind in the colon, except given in large doses, and when it acts as a slight laxative, and so expels the putrefying mass which forms the wind.

In some cases it removes pain and vomiting, probably, like charcoal, by preventing the formation of acrid acids, which irritate delicate and irritable stomachs.

We suggest that it acts by retarding or preventing some forms of fermentation and of putrefaction. J. Mekulics shows that glycerine prevents putrefaction of nitrogenous substances, as of blood diluted with water, which speedily decomposes at the ordinary temperature of the air. Two per cent. of glycerine retarded decomposition for twenty-four hours; 10 per cent. for five days. If the fluid were placed in the hatching oven, then 2 per cent. retarded decomposition for several hours, 10 per cent. for forty-eight hours, and 20 per cent. altogether prevented putrefaction. He also proves that glycerine destroys bacteria and prevents the formation of septic poison, though it will dissolve and preserve the septic poison itself.

Dr. E. Murk finds that 2 to 3 per cent. will delay lactic fermentation in milk from eighteen to twenty-four hours.

Burnham Wilmot, 1860, says glycerine preserves meat so that after several months' immersion the meat is sweet and can be eaten; and Demarquay proves that both animal and vegetable substances may be kept for six weeks to two months by glycerine.

Glycerine, however, does not prevent the digestive action of pepsin and hydrochloric acid; hence, while it prevents the formation of wind and acidity, probably by checking fermentation, it in no way hinders digestion. We administer a drachm to two drachms either before, with, or immediately after food. It may be given in water, coffee, tea, or lemon and soda water. In tea and coffee it may replace sugar, a substance which greatly favors flatulence, as, indeed, does tea in many cases. In some cases a cure does not occur till the lapse of ten days or a fortnight.

Dietetic Treatment of Cancer.

Professor Beneke, of Marburg, in *Berlin Klin. Wochenschrift*, No. 2, 1880, repeats a former suggestion of his, to the effect that by dieting patients with cancer, and especially those suffering from its soft forms, with food from which the albuminates, the alkaline and the earthy phosphates are, to a great extent, excluded, much may be done to check the abnormal cell-proliferation, and prolong, if not save, the patients' lives. He assumes that cancer cells are relatively rich in choleastearin, leathin, and the above-mentioned phosphates, and the great source of these is animal food. Hence, Dr. Beneke's cancer diet allows only fifty grams (barely two ounces) of meat, weighed before cooking, *per diem*, supplemented with a little fish in the form of anchovies, *sardines à l'huile*, or fresh herrings. Butter, sugar, rice, sago, potatoes, cream, nearly all kinds of fruit and green vegetables, are allowed, but bread is given sparingly or replaced by biscuits in limited quantity, and milk is excluded. As drinks, black tea with cream, cocoa, light Moselle or Rhine wines, and occasionally champagne, are allowed. Beer, owing to its richness in alkaline phosphates, must only be sparingly taken. Professor Beneke gives a diet-table for each meal in the day, the details of which we have not space to insert. He calcu-

lates that by following his rules the normal ratio of the nitrogenous to the non-nitrogenous constituents in ordinary mixed diet—namely, 1 : 5—can be reduced to 1 : 8 or 9. The potassium salts also enter the body chiefly as vegetable combinations, and not as phosphates, and the alkalinity of the blood-serum is thereby increased so as more nearly to resemble its condition in the herbivora, in whom, Professor Beneke remarks, cancer is very rare. In answer to the possible question, "can a man exist on a diet so deficient in nitrogen and phosphates?" he quotes the *ipsissima verba* of several patients in the affirmative. One of these, an Englishman (affected, however, not with cancer, but with rheumatoid arthritis), has persevered in it for six years, with gain of weight and muscular force, as well also, according to his own statement, of mental vigor. As to the practical value of the method there is at present little to be said. Professor Beneke can muster only eight cases in which it has been tried—five by Esmarch and Oldekop, and three by himself. Two of the five were too far advanced for operation, and soon died; two others also died after several operations. The fifth—a simple cancer of the breast, which was also treated with liquor arsenicalis—was operated on without relapse. Beneke's own three cases were all alive at the last report. It would be easy to try the diet on a large scale, either at the Cancer Hospital or in the cancer wards of the Middlesex Hospital, but, as Beneke insists, it must be strictly carried out, and the theoretical principles on which it is founded must be steadily kept in view by the surgeon in charge. To those patients who require more fat than is prescribed in the diet-table, and who cannot tolerate butter, cod's oil may be given; those inclined to corpulence should take small doses of Carlsbad salts regularly during the "cure." In conclusion, Beneke points out that if, as is probable, the cancerous and the scrofulous diatheses are in many ways diametrically opposed to each other, what his dietetic system seeks is to reduce the former to the latter.

Treatment of Eclampsia.

Dr. B. F. Eager says, in a paper on the above subject, which was read before the McDowell Medical Society, at Henderson, Ky., on the 27th of May, and published in the *Indiana Medical Reporter*, for June, 1880—

When convulsions are met with in children in connection with febrile disturbance, whether of the eruptive or continued type, they are attributable to excessive elevation of temperature, or to irritation of morbid material in the blood, or possibly to a combination of these causes; in either of which conditions the elimination of heat and the irritant contained in the blood is indicated, which may be met by laxatives, diuretics and the warm and tepid bath, the last of which may be resorted to with safety in the exercise of ordinary care by a *gradual* reduction of temperature, which will lessen the excessive heat and encourage free diaphoresis. Take childhood with its persistent diarrhœa, when the nutrition of the brain is disturbed, and its power to preside over and direct the functions of the various organs is diminished, when digestion and assimilation of food become imperfect, then our remedies must be directed to the checking of this rapid depletion, and to the building up of the child by the most easily assimilated tonics and stimulants, together with concentrated liquid food. To meet this tonic and astringent indication I know of no remedies better than iron sulph. and arom. sulph. acid; the latter I would give if necessary in larger doses than is usually recommended by the books. Brandy would do well as a stimulant. As soon as the persistent discharges yield to this treatment I would prefer bitter wine of iron, as it seems to me an efficient tonic peculiarly adapted to children. Cod-liver oil would be of decided advantage in this condition, and as an efficient aid to digestion I would suggest lactopeptine in full doses until the digestive organs had regained sufficient tone to dispose of such food as would best suit the child.

Another source of this trouble among children is the presence of irritants in the alimentary canal, such as food of indigestible character, an excessively acrid condition of the intestinal secretions, or occasionally worms. If this irritant is confined to the stomach an emetic will promptly relieve, and unless this be accomplished it should be followed by a purgative, and should the indications be sufficiently clear I would combine anthelmintics with the latter.

Iodide of Ethyl in Asthma.

Daniel R. Brower, M.D., writes to the Chicago *Medical Journal and Examiner* for July, 1880, as follows:—

I have recently had a very satisfactory experience with this remedy in an obstinate case of asthma.

The patient is a youth about fifteen years old, who inherits instability of nervous action from both parents. He has had obstinate attacks for six years past, especially during the spring and summer months.

The only complete relief he has heretofore had has been by change of residence. He has tried about all the remedies that have been suggested, such as nitrate of amyl, chloral, morphia, bromide, belladonna and galvanism, without benefit. Partial relief was obtained for some time, by smoking a portion of the following combination, which, in some cases has acted well:—

℞.	Dracenti rad. pulv.,	ʒ j	
	Stramonii foliæ pulv.,	ʒ j	
	Lobeliæ pulv.,	ʒ vj	
	Potassii nitratis pulv.,	ʒ ss.	M.

In the attack that commenced this spring this recipe seems to have been of but little service. I therefore ordered him, as recommended by Prof. Lee, of Paris, inhalation of the iodide of ethyl. The preparation used was made by Nesrck, of Darmstadt, and imported by E. H. Sargent & Co., of this city.

After several trials we found the effective dose to be six drops. This relieved the paroxysms as if by magic, and no unpleasant symptoms followed its use. The only new sensation there seems to have been experienced was occasionally a slight

sense of numbness in the feet and hands. Under its daily use the intervals between the paroxysms have grown longer, and the severity of the attacks has been relieved.

It may be well to add, that for some time past, previous to the use of the iodide of ethyl, I had been giving him iodide of potassium with tonics, but the surprising effects upon the paroxysms were clearly due to this new remedy for asthma.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——We have received a reprint from the Louisville *Medical News*, June 12th, 1880, containing an article on the "Irritable Bladder in the Female;" by L. S. Oppenheimer, M.D., of Seymour, Ind.

——"The Therapeutic Value of Iodide of Ethyl" is the title of an article by Robert M. Lawrence, M.D., of Boston, which comes to us in the form of a reprint from the New York *Medical Record*, June 19, 1880.

——*Godey's Lady's Book*, for August, besides a beautiful frontispiece, entitled "Summer," has its usual attractions in the way of the latest fashions, and also a considerable amount of interesting reading matter.

——*Lippincott's Magazine*, for August, has a number of contributions well selected for summer reading. "American Aëronauts," by Will O. Bates, and "Canoeing on the High Mississippi," by A. H. Siegfried, are, as their titles indicate, records of adventure and exploit, very agreeably written and well illustrated. "An Old English Home," by Rose Kingsley, daughter of Canon Kingsley, gives a graphic account of a famous country-seat, Bramshill House, and contains much personal anecdote, as well as some vivid bits of word painting. "Where Lightning Strikes," by George J. Varney, is full of curious facts and useful hints. An article on "The Early Days of Mormonism," by Frederick G. Mather, is based chiefly on material derived from eye-witnesses. "Dungeness, General Greene's Sea-Island Plantation," is described by Frederick A. Ober. Amelia E. Barr writes of "National Music as an Interpreter of National Character." "Adam and Eve" and "Studies in the Slums" are continued, and there are several short stories, of which "Mallston's Youngest," by M. H. Catherwood, is the most original and striking. The "Monthly Gossip" is varied and attractive, and there are poems by Edgar Fawcett and others.

BOOK NOTICES.

Half-Yearly Compendium of Medical Science. Part xxvi. July, 1880. D. G. Brinton, M.D., 115 South Seventh street. pp. 298. Price $2.50 per year.

The July number of the *Half-Yearly Compendium* contains articles on one hundred and thirty-nine subjects, and from one hundred and thirty-six writers, who have during the past eight months contributed important articles to periodical medical literature, both in this country and abroad. Every department of medical science is represented, some of the articles being in the words of the original, while others, especially those by foreign authors, are given in abstract. The contents of the *Compendium* are so arranged that each department is paged separately, in order that when the series is complete it may be broken up and bound in separate volumes, one of each department. The running page of the number is *at the bottom of the page.* The publisher offers the *Compendium* to subscribers to the Reporter at $2.00 per year, and as its field and its contents are wholly separate from that of the weekly, the combination makes one of great value to practitioners.

Transactions of the Medical Society of the State of Tennessee, at its Forty-seventh Annual Meeting, 1880. pp. 158.

The president, in his address, spoke of the progress which has been made and which is yet to be made in scientific discoveries, and suggested the possibility of the existence of a third form of life, outside of the animal and vegetable kingdoms, a kingdom of parasites and disease causes, living and preying upon the other two, but not amenable to the same laws which govern other life.

Among the papers read were: "The Use of the Obstetric Forceps," by Dr. Thomas Mendus; "Open Treatment of Amputations—Pyæmia and Septicæmia," by Dr. G. B. Thornton; "Report of a Case of Femoral Hernia," by Dr. W. T. Hope; "Hypodermic Medication," by Dr. T. J. Tyner; "Hypermetropia," by Dr. Van S. Lindsay; "Iodine as a Substitute for Quinia," by Dr. Fordyce Grinnel; "Insanity Dependent upon Physical Disease," by Dr. W. P. Jones; "A Case of General Cirrhosis," by Dr. W. J. Miller; "Traumatic Cataract," by Dr. J. G. Sinclair; "Bowel Diseases of Infantile Life," by Dr. Deering G. Roberts. The papers were brief and practical. Lists of the members and of deceased members are appended, and also the code of ethics and by-laws of the Society.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	**$5.00**
Half-Yearly Compendium of Med. Science,	**2.50**
Reporter and Compendium, - - -	**7.00**
Physician's Daily Pocket Record, - -	**1.50**
Reporter and Pocket Record, - - -	**6.25**
Reporter, Comp. and Pocket Record, - -	**8.25**

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

SEX IN EDUCATION.

In our recent discussion of some of the medical aspects of education, we omitted to say anything of this question as it relates to the difference of the sexes. The omission has been brought to our mind, and we cheerfully devote a few words to it.

The questions which interest medical men in relation to this subject are mainly these: Are girls physically adapted to sustain the same course of study as youths? Is the co-education of the sexes desirable? What limits does physiology set to the business and professional education of women?

The first of these inquiries seems to us to have received a positive reply in the affirmative by that inexpugnable authority, experience. The doubt was long raised that as much brain work as youths perform would interfere with the regularity of the menstrual function in girls; and that the sickness incident to these periods would prevent them from equal competition. The facts are not so. Either the brain work of the average youth is never enough to hurt the average girl, or else the latter can stand more than she has hitherto had credit for; the result of large experiments, carefully conducted, prove conclusively that the girls of this country can carry out the course of study in our high schools and colleges without exposing themselves to either more sickness or greater mortality than the other sex. There are, moreover, quite as many examples of distinguished scholarship among the girls as among the boys.

There is no such unanimity on the question of the co-education of the sexes. Up to the present time the best authorities differ. Friends of the movement point to numerous institutions where the sexes are educated together with the best results. The diffidence and coarseness of the boys almost wholly disappear; the audacity and coquetry of the girls are hardly known. The sexual erethism, which in both sexes is so mightily fostered by isolation and segregation, quite disappears in the indifference produced by familiarity.

President Noah Porter, of Yale College, in his work on Education, acknowledges that considerations of health offer no decisive objections; that in some institutions the presence of both sexes appeared to be advantageous to the morals of both; that serious physical evils as well as moral ones attend the isolation of boys in schools and colleges; but that, for all that, there would be such dangers to modesty and purity in the education of both in many institutions, that in his opinion the system should be confined to very narrow limits.

We must leave the inquiry, therefore, without any positive answer, though believing that the accumulating evidence is in favor of the plan of co-education under certain not severe restrictions.

A more vital question is the fitness of woman for pursuits hitherto generally supposed to be only adapted for men. There has been a great deal of cant and selfishness expended in the arguments against her. All the talk about her smaller brain and her weaker powers belongs to

this category of cant. Most educated women one meets impress one as quite the intellectual equal of the ordinary doctor, lawyer, or preacher—often as his superior. With the same technical training as these, the woman would probably do as well or better, inasmuch as she neither drinks, smokes, chews, talks politics, races horses, nor seeks doubtful characters of the other sex—habits, one or all, that very few professional men are free from.

The physical disqualifications she is under are those of menstruation and motherhood. In regard to the former, Dr. Mary Putnam Jacobi has shown, from a large study of American women, that only a small minority are disabled from active work by their monthly sickness, and that, in the majority, it does not interfere at all with their regular pursuits of whatever nature.

Pregnancy, maternity and serious uterine diseases are positive though temporary and not universal obstacles. They must certainly debar woman from many pursuits, and prevent, at least, the regular attention to others. Those, however, who have seen the steady labor in the fields undergone by the peasant women of Europe, and that at the counter by the wives of the bourgeois of Paris and other French cities, or the heavy burdens carried by women over almost impassable roads in the mountainous districts of Norway and Sweden, the carrying power of two women being considered equal to that of one horse, certainly must acknowledge that much that has been written on this subject, in this country, is singularly futile, and either the product of ignorance or partisanship.

The proper position for a scientific mind to take, and the only way in which this question can be satisfactorily settled, is to let it be brought to the test of experience. Give women free access to all trades, vocations and professions. Put no obstacles in their way. Let them try their strength in all arenas. Where they are competent they will be competitors; where they are not, the iron law of the extinction of the unfit will operate to drive them back, without the need of any artificial obstructions.

Notes and Comments.

Therapeutical Notes.

REMEDY FOR SICK HEADACHE.

Dr. J. E. Stinson, of Montague, Texas, recommends the following mixture in the Peoria *Medical Monthly*, for July, 1880:—

℞. Tinct. opii.
Fl. ext. colocynth., āā ℥ss
" valerianæ,
Spt. ether. comp., āā ℥j. M.

Sig.—Give a teaspoonful every three hours until relieved.

After the attack has passed away he places his patient on the following nerve tonic:—

℞. Fl. ext. colocynth., ℥j
" nucis vom., ℥ij
" cinchonæ, ℥ij
Spt. frumenti, ℥iv. M.

Sig.—Teaspoonful five times daily, to be discontinued during the attacks.

COD-LIVER OIL AND IODOFORM.

According to *Progrès Med.*, June, 19, 1880, Dr. Fonssagrives, having ascertained that the addition of iodoform and essence of anise effectually masks the repulsive taste of cod-liver oil, always employs this combination in cases where the union of iodine with cod-liver oil is indicated, iodine being conveyed into the economy in a larger proportion by means of iodoform than by any other preparation. Patients, after comparing this mode of taking cod-liver oil with the ordinary modes, unanimously declare in favor of the taste and smell of the former. To one hundred grams of the oil a quarter of a gram of iodoform and ten drops of the aniseed are added.

A Difficult Case of Stone in the Bladder.

We learn from the *British Medical Journal*, June 26, 1880, that at a recent meeting of the Imperial Medical Society of Vienna Professor Dittel related the following case. A merchant, aged 48, had for ten years suffered from disease of the bladder, and for four months had had symptoms of stone. Having ascertained the presence of a calculus, Dr. Dittel performed lithotrity twice. A quantity of detritus, consisting of phosphate and oxalate of lime, was removed; but the principal mass of the stone resisted crushing, and Dr. Dittel suspected that it was sacculated. He directed an assistant to introduce his finger into the rectum and push the stone forward; but still he was unable to seize it. As a result of the lithotrity, a large number of fragments of stone came away; but one remained so firmly fixed in the fossa navicularis, that urethrotomy was necessary for its removal. After four days

a similar accident occurred, and the wound had to be reopened to remove the fragment of stone. On May 2d Dr. Dittel performed lateral lithotomy. On introducing his finger into the bladder, he reached the diverticulum, but found that the stone was so closely grasped by it that, after trying for an hour, he found it quite impossible to pass his finger between the calculus and the wall of the sac. He therefore decided to perform the high operation, but was still unable to dilate the diverticulum with the finger. He then introduced a scoop between the wall of the diverticulum and the stone, and endeavored, until he became wearied, to raise the calculus from its bed; an assistant then continued the attempt, using the symphysis pubis as a fulcrum, and applying leverage with all his force until the handle of the scoop was bent. After these attempts had been carried on for an hour and a half the stone was at last broken up and removed in fragments. Considering the severe handling which the parts had undergone, the most unfavorable result was naturally expected, especially as parenchymatous hemorrhage from the wound set in some hours after the operation, rendering it necessary to plug the rectum. The patient became collapsed, and nausea, vomiting, and other symptoms of peritoneal irritation appeared. The case, however, ran a favorable course. Fourteen days after the operation the patient was free from fever, and the wounds were perfectly clean.

Erythrophleine—The New Cardiac Sedative.

The *Lancet*, July 3d, 1880, informs us, that in 1876, MM. N. Gallois and E. Hardy discovered in the Erythrophleum guineense, a leguminous plant, an alkaloid, erythrophleine, which they found to possess poisonous properties, and a remarkable action on the heart. The latter suggested to MM. Sée and Bochefontaine the probability that this alkaloid might be found useful in cardiac diseases. They therefore instituted a series of preliminary investigations into its physiological action, and especially into those effects which could be recorded by the graphical method. They have communicated the results to the Académie de Médecine. They examined first its effects upon frogs, and subsequently those upon rabbits and dogs. The latter series are the most important. Hypodermic injection was chiefly employed. A centigram, introduced beneath the skin of a dog, had no effect. Twice the quantity killed a large dog in two hours. They found that while one milligram per kilogram of body weight had no appreciable effect, a milligram and a half was fatal in a few hours. The toxic power of erythrophleine appears thus to be about the same as that of Homolle's digitaline. The first sign of the toxic effect consists of restlessness, followed by a period of weakness, and this by vomiting or efforts at vomiting. The latter are the true initial symptoms of the toxic action, and if the dose of the poison is not too great, they may cease. The animal then quickly returns to its normal condition. The circulatory apparatus is affected in a manner somewhat similar to the digestive. The intra-arterial pressure is increased, the pulse becomes irregular and then retarded. The retardation is characterized by the force of each pulsation, and by the uniformity of the intra-arterial pressure, which is not modified by the respiratory movements, as it is in the normal state. This period is followed by another, in which the pulse is extremely quick and feeble. The influence of the respiratory movements on the blood-pressure reappears, the intra-arterial tension gradually lessens, the cardiac pulsations become weaker and weaker, and cease for a moment from time to time, and are at last permanently arrested. The respiratory movements seem to be directly influenced by the poison, as well as secondarily by the effect on the circulation. At first they are, as a rule, slightly slower and deeper than normal. When the heart's action is accelerated toward the end, the respirations are frequent and extremely energetic. In almost all the experiments the movements of respiration ceased at the same time as those of the heart, but in several cases the movements recommenced, and continued with energy for one or two minutes. The poison has a distinct action upon several parts of the nervous system. Thus faradization of the peripheral portions of the pneumogastric nerves in the neck does not arrest the heart of an animal under the influence of erythrophleine as it does that of a healthy animal, and faradization of the central extremities of these nerves does not accelerate the heart as it does in a healthy animal. Nevertheless, this procedure causes the same rise in pressure as under normal conditions. Immediately after death the heart is found in diastole, flaccid, but full of blood. Sometimes the ventricles present a tremulous movement similar to that which is seen after they have been faradized. Usually the heart has not lost its electrical contractility. The pneumogastric nerve retains its action on the stomach. The excitability of the phrenic nerves is, however, lessened or even lost, while that of the sciatic nerve and of the sympathetic is not diminished.

The Diagnosis of Cancer of the Stomach.

The *British Medical Journal*, July 3, 1880, states that at a recent meeting of the Paris Société de Biologie, M. Leven pointed out to the Society the great difficulties that are sometimes met with in the diagnosis of cancer of the stomach from simple dilatation. The so-called uncontrollable vomitings are present in both cases. To prevent these vomitings, M. Leven recommends that the patients should take solid food once a day (150 grams of meat), so as to avoid congestion of the mucous membrane. The rest of the alimentation consists of a *litre* and a half of milk and six eggs in the course of the twenty-four hours. If at the end of eight days of this regimen the vomitings be stopped, it may be taken as certain that there is no cancer of the stomach. In support of his opinions, M. Leven related the history of two patients whom he treated in this manner, and effected a cure.

Extraordinary Case of Ascaris Lumbricoides.

Dr. Fauconneau-Dufresne relates the following case in *l' Union Méd.*, May 1880, which, as regards the number of worms discharged, he believes to be unique: In the year 1876, a lad, twelve years of age, exhibiting some symptoms of worms, some chopped garlic boiled in milk was administered to him, and in the course of the day he passed at different times fifty ascarides lumbricoides. He continued to pass more and more every day, so that he evacuated as many as six hundred in the same day, the worms being enveloped in a mucus resembling white of egg in appearance, and rolled up in a ball, separating themselves after their ejection. At first they were only passed by the anus, but in a short time they were expelled also by the mouth, and in the end exclusively by the latter. During five months he did not fail to discharge worms daily, generally from three hundred to four hundred. When Dr. Fauconneau-Dufresne first saw the boy, in July, 1878, he had passed fewer for some time past, and he found him with a pale, puffed, and very emaciated face, eating much, but usually vomiting his food soon after he had taken it. Sometimes the worms were expelled with the food, but generally they were voided alone. The worms were discharged living, were five or six inches long and about as broad as a quill. Besides the garlic, he had taken some pomegranate, and now castor oil and calomel, together with occasional doses of garlic, were prescribed. This treatment produced a continuous diarrhœa; but he had a good appetite, passed fewer worms, and was able to go out, and even to school. Seen again in January, 1879, when Corsican moss was prescribed. The worms were passed less frequently during this month, and in smaller numbers, and almost always dead. During February the moss was continued, with occasional purgatives, and the worms were much fewer, and dead. In March and April both dead and living worms were discharged; and at the end of the latter month santonine and calomel were prescribed. These had to be suspended from time to time, but the number of worms kept continually diminishing, and from August, 1879, to May, 1880, none whatever had appeared. The total number of worms counted during the three years, and for the most part ejected by vomiting, was 5126; many more than this having also been passed without having been counted. The greatest number recorded by M. Davaine amounted to 2500, which were passed in the course of five months.

Foreign Bodies in the Œsophagus in Children.

The *Medical Times and Gazette*, June 26, 1880, informs us that Dr. Lannelongue, in a communication to the Société de Chirurgie, stated that during the three years he has been surgeon to the Ste. Eugénie Hospital, he has extracted foreign bodies from the œsophagus eighteen times, in children from eighteen months to six and a half years of age. In thirteen instances these were pieces of money, and in most of the others the articles came from toy houses. Children to whom this accident occurs do not usually own it, for fear of being scolded, and it is only when unpleasant symptoms occur that they complain. These symptoms generally consist in difficulty of swallowing, pain, with disturbances of respiration and phonation, often of reflex origin. Some time usually elapses before the child is brought to the surgeon, who has first to assure himself whether a foreign body is really present. He explores the pharynx first by his finger, then with an olivary sound, the action of this latter against the foreign body being often unperceived in consequence of the latter becoming surrounded by mucus and fragments of food. For this reason Graefe's basket is often more useful, as it may succeed in catching the body, although no friction with this has been felt. All the pieces of money in the thirteen cases were fished up by its aid. In one of the cases a miniature flask of curaçoa could be felt by the sound, but was not extracted for fear of breaking it, and at the end of three days it was

passed per anum. Dr. Lannelongue mentions also two cases occurring in adults. In one an onion was swallowed, and having given rise to alarming suffocative symptoms, was crushed by means of a *brise-pierre*. In the other, an old woman declared she felt a pin which she had swallowed. This was simply a delusion, and Dr. Lannelogue having pretended to remove it, the delusion vanished.

Foreign Bodies in the Ear.

Mr. D. McLeod, of Hawick, N. B., states, in the *British Medical Journal*, July 10, 1880, that having lately come across a cherry stone firmly impacted in the ear, which he failed to remove with the ordinary instruments, he adopted the following method, with complete success. Having made an imitation sucker, such as boys use for lifting stones, by attaching a small piece of leather to a strong thread, he cleaned the presenting part of the cherry stone, and then applied the sucker, previously moistened with strong cement. By means of a small wire he pressed it firmly against the stone, and allowed half an hour to elapse before attempting to withdraw it. On doing so, he found a considerable pull necessary (as the stone had been in forty-eight hours); but the cement had adhered so firmly that he had no difficulty in extracting the stone.

Correspondence.

FOREIGN.

Letter from Germany.

Ed. Med. and Surg. Reporter:—

Munich, July 5th, 1880.

In the visit which I have just made to Berlin and Munich I have been impressed, as every observing visitor must be, with the remarkably active scientific life, the signs of which one sees in all directions. I might say the same with reference to artistic and economical endeavor, but I shall just now confine myself to a few of the medical topics which are now undergoing discussion.

When I was in Berlin the June meeting of the Anthropological Society took place. Among the subjects actively discussed was the development of the color sense. Your readers may have noted that last winter an ophthalmologist of note, Dr. Hugo Magnus, published a monograph undertaking to prove that this sense had greatly developed within the historic period, and is, in a sense, the product of the training that comes from civilization. He closes his pamphlet with a quotation from Tyndall, to the effect that refinement and evolution of sensory perception are brought about by intellectual culture, and that in the future new and strange realms of nature will lie opened to us by this process.

All this pretty theory was attacked and utterly annihilated by Dr. Rückhardt, in the meeting referred to. From a wide study of ancient writers, savage races and young children, it appears unquestionable that in the history, both of the race and the individual, the color sense is developed very completely and very early. It is true there is often a marked deficiency in language when it comes to defining colors; but Dr. R. ingeniously explained this by calling attention to the two facts that the sense of sight, alone of the senses, notes several impressions simultaneously, and that color is not susceptible of examination by any other sense. Hence, the difficulty of forming words which convey definite ideas of color.

The interest of the above discussion to physiologists need not be emphasized. But I pass to some more practical points. One of the most recent issues of the *Klinische Vorträge* contains a lecture by Prof. Kussmaul, on peristaltic disturbance of the stomach. This is a well known concomitant of pyloric stenosis, especially when combined with hypertrophy of the muscular coat of the stomach. But it is not this form of it to which Kussmaul calls attention; on the contrary, to one unattended by either of these conditions, and which, in fact, is a neurosis. It is not uncommon in nervous women and dyspeptic men. There is a feeling of contracting and twisting at the epigastrium, especially in the morning, often accompanied by rattling internal sounds (*clapotement*), and a taste of gall in the mouth on awakening. The peristaltic motion can be detected in thin subjects by careful palpation; sometimes they are even plainly visible to the eye.

The sensation to the patient is sometimes that of a living creature moving in the stomach, and the stories of snakes and lizards in the organ are generally attributable to the presence of these nervous tormina. The treatment by faradization, cold baths, a regulated diet, and carbonated waters, is generally successful.

A few days ago, in this city (Munich), a very flattering testimony of appreciation was offered the eminent Professor Von Nussbaum, on the occasion of the twenty-fifth anniversary of his acquiring his doctorate. The students formed a torchlight procession, the newspapers all gave a history of his brilliant career, and the brother of the King, himself a doctor, and a student of Professor Nussbaum, came to the city to congratulate him.

I naturally supposed the local medical journal would have a full account of it; but to my surprise, I was informed that there was no medical journal published here! Think of it! What a contrast to our country, where the trade of editor comes by nature to every enlightened citizen!

Of therapeutic novelties, I may refer to the benzoates of potash and magnesia, which were, last winter, so lauded by Krebs, of Prague, and other Austrian physicians. They do not seem to gain ground, and I am told have not answered expectations.

The petroleum products as vehicles are popular, and are advertised at many drug stores.

Monrovius.

DOMESTIC.

The Diploma Traffic—What the State May Rightfully Do Against Medical Impostors.

ED. MED. AND SURG. REPORTER:—

In view of the evils of medical imposition, and the ease with which medical diplomas may be obtained, it should be earnestly inquired, *What ought the State to do in the premises?*

To reflect upon the people—to say that they *want* to be humbugged—that they must look out for themselves—will not do. If they are ignorant they should be enlightened by those having the ability to do the beneficent work.

To reflect upon legislators—to say that they are indifferent to the evils complained of—that they are in league with impostors, and deaf, alike to the groans of the wronged and the appeals of the medical profession—will not do.

If they heed not the petitions every year sent to them—if medical men and medical organizations memorialize in vain—it is because the action asked for, the bills brought forward, are not consistent with individual rights, nor adequate to the public need.

To tell legislators that a medical diploma is a *sine qua non* to the safe and successful practitioner of medicine, is to tell them what they know to be false.

Beginning with such an assumption, and going on to ask for the erection of a medical inquisition to examine the credentials of all practitioners of medicine, and to determine which will entitle the holder to treat the sick and which will not, it is no wonder that the intelligent representative of the people hesitates and refuses to vote for the measures asked for.

In various parts of the country he is acquainted with practitioners never favored with college privileges, never the recipients of medical diplomas, who are highly successful, and much esteemed by those well acquainted with the quality of their practical work; and to authorize a censorship that may condemn such men to an ignominious retirement, or subject them to an examination by their competitors for medical patronage, he will not readily consent.

When every preacher of the Gospel is silenced if unable to exhibit a diploma from a theological seminary, or unwilling to undergo an examination in theology and church polity conducted by some of his fellow-preachers; or when every lawyer is driven from the bar who holds not a diploma from a law school, or cannot pass muster before a committee of his associates—then it may seem consistent for them to support the medical censorship advocated by some members of our profession.

November 3d, 1801, the great and good Benjamin Rush, in his introductory to the class, in the University of Pennsylvania, said—

"Conferring exclusive privileges upon bodies of physicians, and forbidding men of equal talents and knowledge, under severe penalties, from practicing medicine within certain districts of cities and countries, are inquisitions, however sanctioned by ancient charters and names, serving as the bastiles of our science."

These are noble words, breathing the spirit of freedom and of truth.

You ask, "What, then, is to be done, to check the selling of diplomas and the impositions practiced upon the people by ignorant and designing men? Can the State do nothing?"

I answer that the State can and ought to do much in this way.

In regard to schools, let it be enacted that no institution shall confer the degree, *Doctor of Medicine*, that has not a specified, necessary curriculum, a session of a specified length, and then only upon candidates coming up to a certain standard of scholarship upon examination.

No amount of legislation can ensure anything like uniformity, or equality of excellence, in teaching or learning, in medical schools.

Some will be more thorough than others. Some will excel in one department, and come short in another; so that differences must exist.

To meet this and other difficulties the State can also enact the following laws:—

1. That no practitioner of medicine or surgery, in any of its departments, shall practice his profession one week, in any place, without appearing before the County Clerk for registration.

2. That in a register provided for the purpose and kept open to all citizens for inspection, he shall record his name, with all titles or insignia of learning thereto attached, and then a statement of the place where, the time when, and the preceptor with whom, he began the study of his profession.

3. That he shall also record the name of the school or schools of science and medicine in which he was a student, mentioning the time of entering and of leaving such institutions, and what degrees, if any, he took at any one of them.

4. That he shall also record the name of every place at which he has been engaged in the practice of his profession, when he went to such a place and when he left it.

5. That to his record, thus made, he shall subscribe his name, under oath that each and every statement written is strictly true.

6. That upon complaint by any citizen that a false record has been made, the physician making it shall be arrested, and upon conviction, punished, as provided by law, for perjury.

Such laws the Legislature can enact without infringing the rights of any citizen; and they would give to every community the much needed information regarding the medical studies and experiences of those essaying to practice the healing art.

As medical schools differ in excellence, and their diplomas in value, each medical man would have all deserved credit allowed him, by reason of his record.

If he had been at the best schools, and if he had been long in practice, the facts would appear.

If he had been at the poorest, or at none at all, he would have just the measure of reputation earned—no more, no less.

If the people desired the physician who had spent the longest time in study, or been at the most celebrated seats of learning, or had the largest professional experience, they would know which to select.

With such information, provided in an authentic manner, the citizen would be able to form an

opinion, in advance of a practical trial, of the probable qualifications of a medical man. If with such light he preferred the uneducated and the inexperienced practitioner, it would be at his own risk; he alone, and not the State, would be responsible for the consequences.

I am persuaded that were we to unite in asking our Legislatures to enact such laws, they would heed our call, and provide light for the people, and so, relief from the evils of bogus diplomas and bogus doctors. J. P. DAKE, M.A., M.D.

Nashville, Tenn.

NEWS AND MISCELLANY.

The Anti-Vivisectionists in England.

The *Medical Press and Circular*, of July 7, 1880, observes:—

The Anti-Vivisectionists have had their great palaver last week. Their chief talkers were Sir Alexander Malet and Lord Haldon—whoever they may be—and Lord Shaftesbury, and the usual amount of ignorance and prejudice was displayed, with the usual determination of such folk not to hear or know anything which does not tally with their own ideas. From the groaning over the unyielding nature of doctors in general, and the unsympathetic character of the newspapers, we assume that the anti-vivisectionists are beginning to find that the endless talking of nonsense is wearisome when it produces no result. It was resolved, nevertheless, to move in the House of Commons for a return of the discoveries made by means of vivisection, to be made by those who now hold physiological licenses. Though we fully believe that such a return would be valuable to science, we scarcely see how Parliament or the public could be expected to understand it, and we are perfectly certain that it would produce no persuasive effect whatever upon what the anti-vivisectionists please to call their minds. However, if they like to have such a return, biologists are quite ready to give it, and have, in fact, already given it to the public through the columns of the medico-scientific papers, which the anti-vivisectors might read, if they were minded to read anything.

Dr. Tanner's Fast.

On July the 27th Dr. Tanner completed his thirtieth day of fasting, and although he is gradually growing weaker, there are many who now believe he will hold out the remaining ten days. When he began fasting his weight was 157½ pounds; during the first seventeen days he lost 25 pounds, but on taking water he again gained four pounds; since which he has been gradually losing, his weight on the 27th being 130 pounds. He now frequently vomits the water he drinks, and it is doubtful if his stomach will be able to perform its function, even should he survive.

Obituary Resolutions.

At a special meeting of the Alumni Society of the Auxiliary Department of Medicine, of the University of Pennsylvania, held Friday, July 9th, the following resolution was adopted:

WHEREAS, Death having removed from our midst our esteemed friend and fellow-member, B. F. Lautenbach, M.D., PH.D., it becomes us to add our testimony to his rare social qualities and his devotion to science.

Dr. Lautenbach had, during the comparatively few years of his life, by his thorough and efficient physiological researches and experiments, as well as by his writings, emphatically shown that there was such fullness of strength in the bud that the harvest could not have been otherwise than full, rich and abundant.

Though cut down before maturity, we trust that some fruit will be found in the stimulation which must force itself upon us, urging us to labor as earnestly in the cause of science as did he.

Resolved, That we tender to the family of our deceased friend our sincere sympathies in this their sad bereavement; that we cause a copy of these resolutions to be transmitted to them, and that they be published in the MEDICAL AND SURGICAL REPORTER.

DE F. WILLARD,
A. J. PARKER,
GEO. MCCRACKEN,
Committee.

QUERIES AND REPLIES.

Dr. G. F. J., of Ohio, wishes to know how to detect the presence of lead in the urine after the administration of potassium iodide in lead poisoning.

Ans.—We believe the usual test with sulphuretted hydrogen will be the best.

Dr. L. B. T., of Ohio, asks some one to give directions for making Knapp's test for sugar with mercuric cyanide.

A Subscriber requests formula for a reliable depilatory which will effectually prevent the return of hair or whiskers on the face.

Dr. W., of Ohio.—Batley's Sedative is, according to the National Dispensatory, prepared as follows:—

Three ounces of extract of opium are dissolved in thirty ounces of hot water, and the solution filtered and mixed with six ounces of alcohol.

Dr. G. M. H., of Ohio, asks:—When a snake swallows an animal of considerable size, is its digestive power strong enough to digest the bones of the animal, or are they passed entire?

Dr. L. B. T., of Ohio, writes:—In this country are two or three physicians who, before the law required a diploma, took one course of lectures in a regular college and commenced practice; they have been in practice for years, but have never taken a second course and diploma. Is it allowed under the Code, for a regular physician to counsel with such?

Ans.—Yes, by all means, if they are gentlemen.

BIRTH

HUNTER.—July 22d, at Weldon, Montgomery County, Pa., the wife of John Hunter, M. B. C. M., Glasgow (lately Surgeon Cunard Line), of a daughter.

DEATH.

HUNTER.—July 22d, at Weldon, Montgomery County, Pa., the infant daughter of John Hunter, M. B. C. M., Glasgow (lately Surgeon Cunard Line).

THE

MEDICAL AND SURGICAL REPORTER.

No 1223.] PHILADELPHIA, AUGUST 7, 1880. [Vol. XLIII.—No. 6.

Original Department.

Communications.

THE SUMMER DISEASES OF CHILDREN.

BY WILLIAM B. ATKINSON, A.M., M.D.,

Lecturer on Diseases of Children, Jefferson Medical College, Philadelphia.

(*Continued from p.* 53.)

Next in frequency of occurrence is the ordinary diarrhœa, which is more commonly seen in children who have passed the second year. This is almost invariably the sequence of the ingestion of improper food, or the result of surfeiting. Exposure to cold, or in damp, ill-ventilated apartments, excessive heat, or the irritation of worms, or of teething, alike may cause too frequent discharges from the bowels.

As there can result nothing but confusion from the division of this disease, or rather symptom of disease, according to the plan of some writers, we shall be content to treat of it under two heads:—

First, simple, or non-inflammatory diarrhœa; and second, the more dangerous inflammatory form.

It is well at the outset for the physician to know something of the natural condition of his case, in relation to the frequency of its evacuations from the bowels. What would constitute a diarrhœa in one child would be but the normal state of another. We consequently encounter cases where children have several evacuations in the twenty-four hours, and yet thrive under this condition. Such cases are not subjects for medical interference.

The ordinary healthy infant usually has from four to six alvine dejections in each twenty-four hours, of slight odor, and the color and consistence of mustard paste. But as soon as it is weaned a change occurs, and it soon drops down to two, or at most three, evacuations in the same time. Children eating at the table, and between meals almost as much, might readily be expected to average the same number, but, unfortunately, after they escape from the immediate necessity for close attention on the part of the mother, in the vast number of instances they are systematically, or perhaps necessarily, neglected. The demands of the new baby, the household, the work by which to procure food and shelter, all combine to throw the little ones upon their own resources. They in turn become absorbed in play, and neglect or resist the calls of nature, and she either yields and only enforces her demands at longer and longer intervals, or, enraged, sets up a diarrhœa which will brook no delay.

The symptoms of the approach of diarrhœa are almost as various as its causes. Thus, a child is restless, starts in its sleep, occasionally whimpers or cries out, as from pain, and finally awakes suddenly, with an evacuation more or less profuse, which is repeated at short intervals. Or, without other disturbance, the passages become thin, and more and more frequent, until its weakness and evident exhaustion demand relief.

The stools at first, except in quite young infants, are generally of the natural color, but more watery. In nursing children they are usually of a greenish color, and contain more or less curdy particles from the milk. Here, too, they are frequently quite acid, which more rarely

occurs in older children. At first, pain is wanting, or but slight, and felt just at the moment of the evacuation, which seems to relieve it, but as the disease progresses the pain is apt to increase; rarely, however, amounting to tormina, except when there is great acidity of the discharges. In this condition a burning pain is felt, especially about the anus, and after a number of these acid passages, the scalding of the parts becomes a source of terrible annoyance and distress.

The thirst and appetite vary. At first there is but little desire for drinks, and the want of appetite, if at all noticed, is attributed to the heat, etc. As the disease progresses, and the watery part of the blood begins to be lessened by the excessive discharges from the bowels, nature demands a supply of fluid to maintain the normal condition, and the thirst becomes a prominent symptom. In severe cases the pallor of the face, the pinched features, the loss of flesh, the great feebleness of the movements give evidence of the grave nature of the disease. At this stage it frequently passes suddenly into cholera infantum, or assumes the inflammatory form. Occasionally, it continues without change and becomes chronic.

The color and general appearance of the discharges vary according to the cause of the attack. When the disease is the result of over-feeding, or the use of improper articles of food, the attack is often heralded by vomiting, or futile efforts to relieve the stomach of the offending matters; this is followed by sharp pains; there is acid breath, great pallor, and an appearance of sudden and great debility. When the bowels begin to act, the evacuations are at first lumpy, curdy, generally very acid, mixed with portions of undigested food, varying in color, usually of a light yellow, soon becoming greenish. After several passages, they become very thin and are ejected with painful efforts. Should the trouble not be relieved by the removal of the cause, digestion speedily seems to have entirely stopped, and all the ingesta pass unchanged, great emaciation follows, and the child dies from exhaustion.

It must be remembered that certain kinds of food which are usually regarded as proper for children, are sure to disagree in particular cases. For this reason, great care should be taken to observe the effect of the diet, and it will soon be seen what food is sure to produce bad results.

Cold and dampness generally causes very thin, watery, or mucous discharges, with much complaint of soreness of the abdomen.

When the diarrhœa is the result of heat, and bad hygienic surroundings, or is caused by dentition, the early discharges are merely as a looseness of the bowels, very feculent, and coming almost without warning; but soon they lose any distinctive character, and resemble those which result from any other cause.

In very early infancy much may be done to prevent these alimentary troubles. Nurses, young mothers, all who have the care of infants, should be taught to recognize the importance of avoiding every kind of food for the child but the breast milk. We cannot too strongly urge this, as we constantly find the infant fed, from the very first hours of life, with the most injurious messes. Catnip tea is perhaps the most commonly employed, combining, as is foolishly thought, the virtues of food and medicine; food to prevent it starving, and medicine to cleanse the bowels. We must impress upon nurses and mothers, with the most positive earnestness, the fact that nature provides the food and medicine most appropriate at this period. Let the child be applied to the breast so soon as the mother has had time to rest and recover a little from the excitement and exhaustion of her delivery. This may be in one, two, or even six hours. In the meantime, give nothing whatever to the child; it needs nothing. By this plan we find the infant more ready to seize upon the nipple, and thus provoke the mammary gland to a proper performance of its functions. When the secretion occurs (the breast may already have commenced this duty) the first milk is that which is best suited to the needs of the child, containing, as it does, the colostrum which acts as a gentle purgative to cleanse away the meconium. Usually, by the third day the true milk is abundantly secreted, and all goes on as it should.

But when, as on the contrary we so constantly find, the child is dosed with food rarely appropriate to its age, or medicine, which is always improper, we have set in motion a train which rarely fails to carry it on to disease and often to death. Diarrhœa is the almost invariable result of this well-meant but dangerous treatment.

The above will show one means of prophylaxis. At a later stage the disease may be prevented by a proper regimen, the strict avoidance of unripe or over-ripe fruits, watchfulness as to food which is frequently followed by bowel trouble, no matter how healthy such food may seem to be with others, care to avoid sudden changes of temperature, or exposure to heat or exhausting exercise, etc.

The treatment of non-inflammatory diarrhœa will be first and of most importance to remove the cause or causes, if they can be ascertained and removed. In many instances, when the disease is in its incipiency, this is all that is required; the bowels being relieved of the cause of irritation soon return to their normal condition.

In certain instances of nursing children, diarrhœa of a very intractable form persists without apparent cause; this, however, is speedily recognized on examination of the milk, which is found to contain a large portion of colostrum. In such cases the only method of relief will be the substitution of another wet nurse, or failing in that, the employment of cow's milk.

When the case is seen early, and the symptoms lead to the belief that the attack is the result of the presence of indigestible or undigested matter in the bowels, for either, being a foreign body, acts as an irritant, a small dose of castor oil, of calcined magnesia, or of the spiced syrup of rhubarb may be given, with the view of expelling such matters. It is rarely necessary to continue, or even to repeat these remedies. With a proper regulation of the diet, of the hygienic conditions, etc., in very many cases, the attack ceases, and no further medication is requisite; or a few doses of aromatic powder, v–x grs. every two hours, will complete the cure. Should the looseness of the bowels continue, it becomes necessary to employ an astringent; an alkali if there is much acidity; and some form of narcotic to relieve pain.

Of astringents, catechu, kino, and logwood are most frequently employed.

As antacids, we have bicarbonate of soda, or potassa, lime water, chalk mixture, and bismuth.

Perhaps no formula can be employed with better result, in the great majority of cases, than one combining the subnitrate of bismuth with the compound powder of ipecacuanha.

For a child, one year old, we may give—

℞. Pulv. ipecac comp., grs. vj–ix
Bismuthi subnitrat., ʒj. M.
Ft. chartulæ, No. xij.

Dose.—One every two to four hours, according to the urgency of the symptoms.

In cases where for any reason a mixture is preferable, we may use—

℞. Bismuthi subnitrat., ʒij
Tincturæ opii camph., f.ʒiv
Syrupi simplicis,
Mucilag. acaciæ, āā f.ʒiss. M.

Dose.—Teaspoonful, as before.

It must not be forgotten that blackening of the stools will result from the use of bismuth, and this fact should be mentioned to the mother, as in some instances this condition has created great alarm, as portending a grave complication.

When acidity is a prominent symptom, we may employ with the bismuth the compound powder of chalk, with opium, in doses of one to three grains for a child of one year.

In all cases where opium is employed it is important to watch its effects, and where drowsiness or cerebral symptoms occur, it should at once be omitted. Should a child die comatose, it is difficult to dissuade its attendants from the belief that it has died from the effects of opium. It seems that the whole benefit obtained from the use of this drug is the so-called "putting the bowels in splints." It checks the peristaltic action, quiets the restlessness due to the pain, and thus allows nature to return to her proper condition.

In this connection, we must insist upon the great importance of *rest in the horizontal position.* This is constantly forgotten; the child is carried about over the shoulder of the attendant, jolted on the knee, or in a rough rocker, thus keeping the bowels in a perpetual turmoil. We see the good effects of rest by the almost invariable improvement after a good nap. Therefore, never disturb a child from its sleep, even though the hour for giving the medicine may be at hand.

In persistent cases we may give—

℞. Tr. catechu,
Tr. krameriæ,
Tr. kino, āā f.ʒij
Tr. opii camph., f.ʒiv
Spt. ammoniæ aromat., f.ʒij
Syrup. simp.,
Aq. cinnamomi, āā f.ʒiss. M.

Dose.—Dessertspoonful every two to four hours, according to age and urgency of symptoms.

Where, for any reason, the alcohol may be objectionable, we may employ astringent infusions of catechu in doses of one or more teaspoonfuls repeated as above.

When the discharges are quite offensive, the addition of a small quantity of the solution of chlorinated soda, two to five drops in each dose of the astringent mixture, will correct this trouble and aid in the cure. We prefer this to the use of carbolic acid, which rarely fails to prove so offensive to the child that it obstinately refuses to take the mixture.

An old formula, and one which we have seen to be of great service both in chronic and other

forms of diarrhœa, is the mixture of nitrous acid with opium and camphor water.

℞. Acidi nitrosi, ♏xxv
Tr. opii, ♏xv
Aq. camphoræ,
Syr. simp., āā f.℥iss. M.

Dose.—Teaspoonful every three to four hours.

In a number of instances this has given most excellent and speedy results. Where opium may be contraindicated, we may substitute extract of hyoscyamus, say half a grain in each dose.

We always prefer to give the above doses in two or three times the quantity of solution of acacia, or rice or barley water.

In cases of great restlessness employ the bromide of potassium or sodium, or chloral, or the bromide and chloral may be usefully combined, as mentioned previously. Rest is imperatively demanded for the cure of this condition.

When the skin is hot and dry, tepid sponging is of great value, and by itself often gives so much comfort that the little patient sinks into a refreshing slumber, perhaps the first it may have had for several days.

In cases where much flatulence is present, perhaps no remedies are more useful than chloroform and turpentine. The former may be employed in a formula like the following:—

℞. Chloroformi, gtt. xxx
Tr. opii camph.,
Tr. cardam comp., āā f.℥ij
Mucilag. acaciæ,
Syrupi simplicis,
Aq. menthæ viridis, āā f.℥j. M.

Dose.—Teaspoonful every hour, or even every half hour, or oftener, as occasion demands.

The turpentine may be given as follows:—

℞. Ol. terebinthinæ, f.℥j
Tr. opii camph.,
Tr. cardam. comp., āā f.℥ij
Magnesiæ calcinata, gr. x
Mucilag. acaciæ,
Syrupi simplicis, āā f.℥iss. M.

Dose.—Teaspoonful every two or three hours.

In all cases it is well to commence early with some tonic, and we have found the best and most useful to be the solution of the pernitrate of iron with calumbæ, as mentioned in the previous paper.

During the treatment the physician must constantly remember that the child requires food as well as medicine. Give milk, with a due proportion of lime water, with stimulants added as required, beef essence, beef or mutton tea, chicken, or rice water, also cold water freely. Nothing is gained by cruelly keeping the child suffering with thirst.

(To be continued.)

ANÆSTHESIA BY ETHYL BROMIDE (SUMMARY).

BY H. AUGUSTUS WILSON, M.D.,

Ophthalmic and Aural Surgeon to St. Mary's Hospital, and Surgeon in charge of the Surgical Out-patient Department; Lecturer upon Microscopic Anatomy and Fracture Dressings at the Philadelphia School of Anatomy.

I desire to present in this paper a summary of the facts known, up to this date, in regard to the anæsthetic use of the ethyl bromide.

During last winter I received a dissection wound, which required laying open; my confidence in the ethyl bromide was such that without the slightest hesitancy I consented to pass under its influence.

Dr. Levis poured one drachm upon a folded napkin, and I with my right hand applied it closely to my face. In one minute Dr. Levis asked if I was ready. I could barely understand what was said, but could not reply, and fearing that the knife would be applied, I managed to utter a groan. A second drachm was applied, and in half a minute more the incision was made, without cognizance on my part, and the napkin removed. One half minute more, or two minutes from the time of commencing to take the anæsthetic, I sat up, recognized and called by name a person who had entered the office during my unconscious moments. No nausea or other distressing symptom arose. My efforts at first were directed to watching the influence it would have upon me, but that influence was exerted so rapidly and stealthily, that ere I was aware of it I was in that happy condition which is such a boon to those about to undergo surgical procedures. Thus my apology is made, if apology is necessary, for presenting this subject again to the profession; my object being to incorporate, if possible, the views expressed in some of the recent articles upon the ethyl bromide and its uses.

The ethyl bromide, which was discovered by Serullas, in 1827, received but little attention until Nunneley, of Leeds, England, called the attention of the profession to it, in 1849. It was not long, however, before he was compelled to abandon it, because of its costliness. Rabuteau, of Paris, again evoked interest in the subject, in 1876, in connection with some experiments on animals.

In 1878 Dr. Laurence Turnbull,[3*] of Philadelphia, read a paper before the Pennsylvania State Medical Society, urging the advantages of this article[4] as an anæsthetic.

* The numbers in the text refer to corresponding numbers in Bibliographical Table.

The matter was looked upon passively until Dr. R. J. Levis, of Philadelphia,[5] took hold of the subject actively, in April, 1879, and gave it a trial during his term of service at the Pennsylvania Hospital, and later at the Jefferson College Hospital.

In January, 1880, he published his first article upon the subject. It was not known[6] until after the publication of this article that any experiments on man had previously been made abroad with this agent, and the cautious manner in which each administration was watched showed a desire to understand the *modus operandi* of its application.

That the ethyl bromide occupies its present high standpoint credit is due, first, to Dr. Turnbull, for reviving the attention of the profession to it; and secondly, to Dr Levis, who, with his large hospital opportunities and extended experience with anæsthetics, gave the drug a most careful investigation.

Thus, starting from Philadelphia, its application spread to all parts of this country, and recently word has come to us, through the journals, that it has been successfully introduced into Canada[37] and France.[33,34]

During the past few months a medical journal could hardly be found which did not allude to the ethyl bromide, showing conclusively that the profession, tired of the dangerous chloroform, inconvenienced with the slow, nauseating ether, was ready and anxious to accept an article which promised as much as this new candidate for popular favor. Having watched the growth of the use of this anæsthetic from the time it was first used in the Pennsylvania Hospital, frequently administering it for Dr. Levis, in private surgical practice, more frequently, perhaps, carefully noting the effects when administered by Dr. J. B. Roberts, I have continued to use it in preference to any other anæsthetic, at St. Mary's Hospital, in this city, and in my private practice.

ITS CHEMISTRY.

Heretofore ethyl bromide has been made by using potassic bromide, but as this was made from ferrous bromide, Dr. Lawrence Wolff,[15] a well-known pharmacist of this city, adopted the following method:—

In a stone jug containing about one gallon of water and two-and-a-half pounds of iron turnings, or wire, five pounds of bromine are gradually added, care being taken not to allow the temperature to rise too high, the jug, besides, being placed in cold or iced water; as soon as the reaction has ceased the solution of the green ferrous bromide is filtered off, the remaining iron being well washed out with warm or boiling water, and to it, in a leaden or glass flask, fifteen pounds of commercial sulphuric acid are added. After the mixture has sufficiently cooled six pints of alcohol (95 per cent.) are intermixed, the mixture well agitated and distilled at a temperature of 200°F., and there maintained until the reaction, which will go on quite lively for a while, shall have ceased, and the ethyl, which has rapidly been gathering in a receiver containing about one ounce of water, has ceased to come over, as can easily be detected when it fails to further sink to the under surface of the layer of water. The ethyl bromide so obtained should be shaken with a solution of potassic bicarbonate, subsequently washed with water and purified by re-distillation.

Dr. Wolff says that he has obtained in this way and from these amounts seven pounds of ethyl bromide, at a cost of material of not over $4.30, or about 60 cents per pound.

Thus, if ethyl bromide can be manufactured at this very low cost the objection that Nunneley found will not prevent the article from being used.

At the Pennsylvania Hospital[40] the first twenty-five administrations consumed nearly twelve fluid ounces, or about eighteen ounces avoirdupois. The retail price at that time was $3.00 per pound, thus making the total cost $3.37½. The average amount used in each case was $3\frac{9}{10}$ fluid drachms, costing 13½ cents for each patient.

The cost is governed by the manner of using. If in the bungling and wasteful manner so often seen in the use of other anæsthetic agents, I can readily understand how the cost would be a decided impediment to further use; but if administered as I shall detail later, any one can gain the same results as obtained above in similar cases.

ITS PHYSIOLOGY.

There exist such diametrically opposed opinions with reference to the physiology of this agent, that, instead of discussing them, I shall merely allude to the views held by different investigators and await the results of further experiments.

Dr. H. C. Wood, of Philadelphia,[14] deduces from his experiments on animals that anæsthesia may be obtained without reducing the blood pressure, but when given in excess it becomes a distinct depressant to the circulation, reducing the current of blood to a marked extent.

M. Terrillon, of Paris,[34] says that in no case has he observed any phenomena the nature of

which would cause fears of asphyxia; neither does the ethyl bromide seem to cause syncope.

Dr. Levis[8] observes that as anæsthesia progresses the general circulation shows evidences of moderate excitement, indicated by some increase in the rapidity of the action of the heart and increased arterial tension, the face becoming brightly flushed. Nor does he seem inclined to think there is any likelihood of cerebral anæmia or cardiac syncope; and he further observes, that all anæsthetics become eventually, by continuance, depressing agents.

Dr. W. H. Hingston, of Montreal,[37] notices in man an increased frequency in the heart action, together with an increased respiratory movement, and that the pulse and breathing are less influenced than with ether or chloroform.

Dr. Lawrence Wolff,[15] assisted by Dr. J. G. Lee, Physician to the Coroner of Philadelphia, experimented quite largely with rabbits, and observed that those animals which died, to whom respectively ethyl bromide and ether had been administered, presented similar phenomena.

The mode of death appears to have been by gradual paralysis of the cardiac inhibitory motor centres; while the sudden heart failure in the animal to whom was given chloroform, which is typical of chloroform accidents, seems to indicate paralysis of the cardiac motor centres.

Dr. Wolff believes that these experiments go far to show that a direct toxic influence from pure bromide of ethyl need not be apprehended.

Dr. Ott, of Easton, Pa.,[13] who has made thorough and scientific researches with the bromide of ethyl, experimenting upon frogs and rabbits, believes that the increased frequency of the heart is due to stimulation of the accelerative nerves, or of the cardio-motor ganglia, and the dangers in administering the drug are less than those of nitrous oxide.

MODE OF ADMINISTRATION.

It is of great importance that a preliminary drill should be gone through before commencing the administration of any anæsthetic, that the patient may know what is required of him and coöperate with the administrator. The assurance of freedom from suffering and danger go far to tranquillize the patient's mind and render him willing to observe such directions as it may be advisable to give him.

I cannot too greatly deprecate the careless manner with which anæsthetics are administered, it being an extremely rare occurrence for the patient to have his heart or lungs examined prior to the administration. A careful physical examination should be instituted in every case about to pass into the anæsthetic state, and should signs be present of affection of either of these organs, the administrator would feel increased responsibility, and would be more watchful for the slightest indication of trouble. But the frequent administration of anæsthetics at the present day, together with the rare occurrence of death, has tended to a disregard of danger.

The use of cumbersome mechanical apparatus for the administration of anæsthetics has no advantage over the simple napkin, as used by Dr. Levis.

It is recommended that a folded napkin large enough to cover the entire face be used, and upon the centre of this be pinned several folds of soft linen, about four inches square, upon which is poured, in measured quantities, the anæsthetic.

The patient being upon his back, with his head slightly raised, the preliminary drill having tranquillized him, the napkin is placed over the patient's nose and mouth, and a rapid, decided impression aimed at. The object is to obtain the anæsthetic state as soon as possible, without the intervention of muscular or mental excitement.

The anæsthetic state is usually indicated by a return to normal breathing, resembling that of ordinary sleep. When this condition is reached the application should be continued only as needed to keep the patient in this condition. It must be remembered that all anæsthetics become depressants when pushed to their toxic effect.

Vomiting is less frequent than in the administration of ether or chloroform—Terrillon, Féré, Hingston, Conner, Roberts, Turnbull, Levis—while Agnew, Haynes, Morton and Prince think that it occurs more frequently.

It seems impossible to reconcile these views, unless allowance is made for the impurity of the earlier samples, and the manner in which administration was conducted; for when given as Dr. Levis recommends, I am certain that vomiting is very much less frequent than when ether is given.

The condition of the patient's stomach is, of course, a very important matter, and it is well to have the patient abstain from solid food for at least four hours, and liquids three hours, before being anæsthetized (Levis).

Féré[33] recommends that a fast should be taken from the night before the operation. This may account, in part, at least, for his uniform good results in the administration.

The occurrence or threatening of vomiting

during the progress of anæsthesia indicates that the anæsthetic state has not been reached, and an effort should be made to push the ethyl bromide. It must be borne in mind that a fully anæsthetized patient never vomits.

After the completion of the operation, should nausea present itself, small pieces of ice may be ingested, with decided benefit. The patient should be kept in the recumbent position until all tendency to nausea has subsided.

The ethyl bromide is not available, in my experience, in operations about the nose and mouth, where it becomes necessary to suspend the administration for a time, for the rapid elimination allows the patient to return to consciousness, which is apt to be accompanied with more or less struggling.

After complete anæsthesia has been produced by ethyl bromide, I have found it practicable to continue the anæsthesia by the use of sulphuric ether, which has the advantage, and at times the disadvantage, of keeping up the anæsthetic state a considerable time after the napkin has been removed.

In operations lasting over one hour, it is probably safer to keep up the protracted impression with sulphuric ether; but I can conceive of but few operations which would require such a length of time in performing.

The quantity to be used in an operation must of necessity be governed by the condition of the patient and skill in the administration. In a recent case of scirrhus of the mammary gland, upon which Dr. Levis performed excision, I administered seven and one-half drachms of Wyeth's ethyl bromide, keeping the patient completely under its influence for forty-two minutes. Five minutes after removing the napkin the patient conversed rationally with those about her. In this case there was no nausea, vomiting, or other unpleasant symptom.

The largest amount I have personally known to have been given was eleven drachms during forty minutes, in a case of amputation of the arm, by Dr. Levis. I am unable to understand the necessity of giving the large quantities said to be required (?) in many of the cases where deleterious defects have been noticed or where anæsthesia could not be obtained.

In the case of Dr. Sims, of New York,[9] it is stated that two ounces had been administered during the first twenty minutes, at the end of which time she vomited freely (showing she was not thoroughly anæsthetized). The operation (Battey's) lasted one hour and a half, and about five ounces of the ethyl bromide were used.

It is, of course, a well known observation that those accustomed to alcoholic stimulants are with greater difficulty brought under the influence of anæsthetic agents, but this will not account for all the cases where "it became necessary to resort to ether or chloroform."

In reference to the only case of death occurring while under the influence of ethyl bromide,[39] that occurred at the Jefferson Hospital, on May 26th, 1880, I will briefly state that the patient was in a very debilitated condition, but after being in the hospital week after week, with the intention of improving his condition, and warm weather rapidly approaching, he protested against further delay. A consultation being held, an attempt to remove the vesical calculus was deemed advisable.

On May 26th, 1880, after the administration of a stimulant and fifteen grains of quinine, two fluid drachms of ethyl bromide were given by the resident surgeon. Soon after the patient struggled, when a third drachm was given. A fourth drachm was given later, and anæsthesia was accomplished. Dr. Levis made the incision, when a gentleman who has acquired a well-deserved reputation as an administrator of anæsthetics called attention to the imperfect respiration. The napkin being removed, the lips were noticed to be of a pinkish color, cyanosis apparently not existing.

Let it suffice to say, that nitrite of amyl, the battery, and artificial respiration were resorted to, and not until an hour had elapsed were the efforts suspended.

The post-mortem examination was held two hours after death, by Dr. J. G. Lee, Coroner's physician. Dr. Lee was peculiarly fitted to make the autopsy in this case, inasmuch as he had experimented quite largely with animals, in conjunction with Dr. Wolff.

He found the following conditions present:—

Commencing rigor mortis. In left perineal region an incision two inches long penetrating skin and superficial fascia. Tissues of scalp congested, membranes of brain congested, ventricles containing a small amount of clear serum, brain substance normal; membranes of medulla oblongata congested; substance of medulla anæmic. No odor of ethyl bromide perceptible. On opening body, some slight odor of ethyl bromide was noticeable. The apex of left lung was bound to thoracic walls anteriorly and posteriorly by old (circumscribed) pleuritic adhesions. Upper lobe was partially consolidated, the lung tissue containing a number of cavities, with caseous and purulent deposits.

Upper and lower lobes of right lung bound to thoracic walls anteriorly and posteriorly, by old pleuritic adhesions. Lung tissue consolidated and filled with cavities of various sizes. Trachea and bronchi contained a small amount of pus, otherwise normal.

Right side of heart dilated, auricle and ventricle containing post-mortem clots, concentric hypertrophy of left ventricle, which was contracted, and contained a very small post-mortem clot. Left kidney enlarged and diseased; right kidney enlarged. Liver normal. Intestines normal. Concentric hypertrophy of bladder, which contained at its neck two encysted calculi.

Dr. Morris Longstreth, pathologist to the hospital, made microscopic examinations, and reported as follows:—

Kidneys showed inflammation of pelvis, extending to entire organ. The morbid process in the lung was catarrhal pneumonia; no tubercular deposits were to be seen.

The coroner's jury rendered the verdict of death from exhaustion, due to disease of lung and kidney.

I think that the case teaches one very important lesson, that a careful physical examination should be instituted in every case, prior to administration of an anæsthetic. Had this been done in this case, I question very much if the operation would have been attempted.

SOME VIEWS AS TO THE VALUE OF ETHYL BROMIDE AS AN ANÆSTHETIC.

Dr. A. W. Adams, of Colorado,[16] says, from his small experience in its use, that in view of its patent virtues, *i. e.*, its rapid impression, the promptness of recovery from its influence, its agreeableness, and the non-combustible character of its vapor, it is worthy of a most extensive trial and investigation.

Dr. J. C. Reeve, of Dayton, Ohio,[12] remarks: "My personal experience with hydrobromic ether fully sustains the observations of others as to its exceeding promptness of action, and the rapidity with which recovery takes place. I can also say that it is pleasanter to inhale than chloroform, which is not very unpleasant, and infinitely pleasanter than ether."

Dr. Woodbury,[38] of Philadelphia. Editorial. "It is probably safer than chloroform, having much the same advantages over ether that chloroform has. But let it be understood that there is no such thing as a perfectly safe anæsthetic."

Dr. H. C. Wood.[14] "If any reader will examine the sudden fall of arterial pressure in Experiment 3, and remember the great expensiveness of the bromide, and the lack of any anæsthetic superiority on its part to chloroform, he will, I think, hesitate about endorsing this new agent."

Dr. Ott[24] draws the following conclusions:—

1. "Bromide of ethyl, by either inhalation or subcutaneous use, kills by a toxic action on the centre of respiration.

2. "That the decrease of force and frequency of the heart contribute to the paralysis of the respiratory centres.

3. "That injections of ethyl into the jugular toward the heart kill by cardiac arrest, probably due to an action on the cardiac muscle.

4. "Bromide of ethyl in toxic doses depresses momentarily the frequency of the heart, followed by a subsequent permanent rise to normal rate.

5. "Bromide of ethyl in toxic doses depresses the actual tension steadily, due in major part to the depressant action of the drug upon the heart; and in minor part to a partial loss of tone of either the spinal vaso-motor centres, or the peripheral vaso-motor system.

6. "The inhibitory power of the pneumogastric is not paralyzed."

Dr. Wolff.[15] "That pure ethyl bromide is, *per se*, an absolutely safe anæsthetic, can, as yet, not be positively stated, but that its action appears to be quite as safe as ether, and certainly more so than the treacherous and dangerous chloroform, seems to us, as a deduction from above related experiments, out of question."

W. H. Hingston, Montreal, Canada,[37] has used no other anæsthetic since commencing the use of bromide of ethyl. There is less resistance and struggling on the part of the patient. Vomiting is less frequent. Eliminated from body more rapidly than any anæsthetic except laughing gas.

"That bromide of ethyl is one of the, and in some respects the, most valuable anæsthetic hitherto used."

Dr. Sims,[9] of New York. "The inference that I draw from the facts in the history of this case is that the anæsthetic was the cause of death, while the manner of death may have been by uræmic poisoning. The lesson from this is, never to give bromide of ethyl in prolonged operations, and never to give it where there is organic disease of the kidneys. What, then, shall we give?"

Dr. Levis.[5] "It is becoming evident that the dread of unavoidable disasters from chloroform and the inconvenience of ether are tending to prevent their humane administration in many

cases where the blessing of anæsthesia is due to the sufferer.

"While feeling inclined to impress caution in regard to the use of so powerful an agent as the bromide of ethyl, I am, from a basis of experience, inclined to recommend its use to the profession, and express my conviction that it is practically the best anæsthetic known to the profession."

USES OF ETHYL BROMIDE OTHER THAN ANÆSTHETIC.

Dr. Roberts, of Philadelphia,[40] records a case of angina pectoris to which he was called that yielded quickly to the anæsthetic use of ethyl bromide.

The ethyl bromide has gained a place in obstetric practice, owing to its speedy action. In some recent cases where I have used it, it has given the greatest satisfaction. A single drachm administered at every premonition of a labor pain carried the otherwise suffering woman through it without complete loss of sensibility, and yet in a perfectly painless state, the process of labor apparently not being retarded.

In two cases of lumbago and one of sciatica I have administered the ethyl bromide hypodermically, in doses of ten and fifteen minims, gaining the same results that are obtained by similar applications of chloroform. The patients complained only of a sensation, first of warmth, later of numbness, for some considerable distance about the seat of puncture, which passed off in the course of a few hours. The pain in each case was very speedily relieved, and in the case of sciatica did not return after the third injection (one having been given on each day).

Dr. Wolff,[15] while testing the action of ethyl bromide upon himself, when taken internally, was suffering with a sick headache, which the drug in question seemed speedily to relieve, and he infers therefrom that cases of nervous irritation and hysteria may receive great benefit from its use.

Dr. Turnbull has used, at his ear clinics, the ethyl bromide, by means of the Politzer bag, for inflating the middle ear, and is much pleased with its action. Upon his recommendation I have used it several times, and am inclined to regard it as a valuable acquisition in the treatment of ear diseases. I have not used it often enough to base any conclusions upon its benefits.

Thus, it will be seen that the ethyl bromide has been used with success as a general anæsthetic in surgery, gynæcology, dentistry, in a case of angina pectoris, and other painful affections; as a local anæsthetic in numerous cases not recorded; by inflation in the treatment of tinnitus aurium; internally, for nervous headache; and hypodermically in lumbago and sciatica.

If a remedial agent possess such a large range of usefulness, and when administered judiciously has yielded such good results, while in its infancy, is it not proper that it should be given the benefit of a longer and more cautious trial, that its proper position may be assigned to it?

That it has been useful cannot be doubted. That it is capable of producing death should be no bar to its proper use, for, in such view, it would become necessary to strike from our materia medica a long list of remedies without which we would be at a sad loss.

512 *Marshall street, Philadelphia.*

Bibliography.

1 *Nunneley.—Transactions* Provincial Medical and Surgical Association, 1849, vol. xvi.

2 *Nunneley.—Proceedings* British Medical Association, in the *British Medical Journal*, August 19th, 1865, p. 192.

3 *Laurence Turnbull.—Transactions* Medical Society of the State of Pennsylvania, 1878.

4 Proceedings Philadelphia County Medical Society, in the *Medical Times*, January 17th, 1880.

5 *R. J. Levis.*—"The New Anæsthetic, the Bromide of Ethyl." Philadelphia *Medical Times*, January 17th, 1880.

6 *R. J. Levis.*—"Priority in the Anæsthetic Use of the Bromide of Ethyl." Philadelphia *Medical Times*, February 14th, 1880.

7 *John B. Roberts.*—"The Bromide of Ethyl as an Anæsthetic." *Medical Bulletin*, Philadelphia, January, 1880.

8 *R. J. Levis.*—"Ethylization; the Anæsthetic Use of Bromide of Ethyl." New York *Medical Record*, March 27th, 1880.

9 *J. Marion Sims.*—"The Bromide of Ethyl as an Anæsthetic." New York *Medical Record* April 3d, 1880.

10 New York Academy of Medicine. Discussion. *Medical Record*, April 3d, 1880.

11 Editorial. *Medical Record*, April 3d, 1880.

12 *J. C. Reeve.*—"Two New Anæsthetics." Cincinnati *Lancet and Clinic*, April 10th, 1880.

13 *Isaac Ott.*—"Bromide of Ethyl, its Physiological Action." Detroit *Lancet*, April, 1880.

14 *H. C. Wood.*—"Notes on Anæsthetics, Chloride and Bromide of Ethyl." Philadelphia *Medical Times*, April 24th, 1880.

15 *Lawrence Wolff.*—"Ethyl Bromide." *American Journal of Pharmacy*, May, 1880.

16 *A. W. Adams.*—"An Almost Fatal Case from the Use of the New Anæsthetic, Bromide of Ethyl." *Medical Gazette*, May 1st, 1880.

17 Editorial. *Medical Gazette*, New York, May 1st, 1880.

18 Editorial. *Clinical News*, May 15th, 1880.

19 *W———.*—"The New Anæsthetic Hydro-

bromic Ether." Boston *Medical and Surgical Journal*, Volume CI., p. 892.

20 *Laurence Turnbull.*—"Remarks on Bromide of Ethyl or Hydrobromic Ether." *Medical Record*, April 17th, 1880 p. 439.

21 *G. F. Souwers.*—"Cases Operated on Under the Influence of Bromide of Ethyl," by R. J. Levis, M.D. MEDICAL AND SURGICAL REPORTER, 1880, vol. XLII, p. 92.

22 *C. H. Wilkinson.*—"Case, with Dangerous Symptoms." *Medical Record*, May 15th, 1880. p. 554.

23 *G. B. Bullard.*—Case. *Medical Record*, May 15th, 1880, p. 555.

24 *Isaac Ott.*—"Bromide of Ethyl; Its Toxicological Action." Detroit *Lancet*, June, 1880.

25 Case. *College and Clinical Record*, February, 1880.

26 *Frank Woodbury.*—"The New Anæsthetic." *College and Clinical Record*, Feb., 1880, p. 26.

27 *E. D. Spear, Jr.*—"Anæsthesia by Ethyl Bromide." Boston *Medical and Surgical Journal*, 1880, vol. CII, p. 214.

28 *R. J. Levis.*—Clinical Report; "Amputation of Thigh Under Anæsthesia from Bromide of Ethyl." *Medical Record*, 1880, vol. XVII, p. 251.

29 *Laurence Turnbull.*—"On Pain and Anæsthetics." MEDICAL AND SURGICAL REPORTER, 1880, Vol. XLII, p. 199.

30 *Laurence Turnbull.*—"On the Use of Hydrobromic Ether as an Anæsthetic for Surgical Operations." *Independent Practitioner*, Baltimore, vol. I. p. 74.

31 *P. H. Cronin.*—"The New Anæsthetic." St. Louis *Clinical Record*, May, 1880.

32 Editorial. "Bromide of Ethyl." *Therapeutic Gazette*, Detroit, May, 1880.

33 *Ch. Féré.*—"L' Anæsthesie par le bromure d'ethyle." *Le Progrès Médical*, June 19th, 1880.

34 *M. Terrillon.*—"*Bulletin de Thérapeutique.*" VI, 1880.

55 *Carl Jungk.*—"Examination of Various Samples of Bromide of Ethyl." *Therapeutic Gazette*, June, 1880, p. 156.

36 *Laurence Turnbull.*—Hydrobromic Ether, or Bromide of Ethyl as an Anæsthetic." *Medical Bulletin*, June, 1880.

37 *W. H. Hingston.*—"Certain Anæsthetics." *Canada Medical Record*, June, 1880.

38 Editorial. *College and Clinical Record*, June 15th, 1880.

39 *John B. Roberts.*—"Case of Death Occurring during the Administration of Bromide of Ethyl." Philadelphia *Medical Times*, July 17th, 1880.

40 *John B. Roberts.*—"The Bromide of Ethyl as an Anæsthetic in Practical Surgery." *Transactions* Medical Society of the State of Pennsylvania, May, 1880.

41 *J. T. Clover.*—"Sims on Bromide of Ethyl." London *Medical Record*, June 15th. 1880.

42 * * * * St. Louis *Courier of Medicine*, March, 1880.

—A report of an epidemic of smallpox in Christiania, Norway, is contradicted. The only patients affected were unvaccinated children.

HOSPITAL REPORTS.

LOUISVILLE CITY HOSPITAL.

RECTAL CLINIC, BY J. M. MATTHEWS, M. D.,

Professor of Surgical Pathology and Diseases of the Rectum, Kentucky School of Medicine.

REPORTED BY A. H. KELCH. M.D.

Treatment of Hemorrhoids.

I imagine it will be better for the class, before presenting the patients, to say a few words concerning the affections, that you may understand the nature of the cases.

As I have often remarked, it is a fact that very few general practitioners diagnose these affections correctly, for the simple reason that they fail to examine the patient. It is a frequent occurrence for the surgeon to find, upon the presentation of a patient to him suffering with internal hemorrhoids, that an ulcer or other trouble has been diagnosed by the physician. Many times a serious condition is supposed to exist, whereas upon an examination a simple affection, easily relieved, is found.

I have not talked to you at all upon the subject of piles, and I propose to do so this afternoon; and in order to make my remarks impressive I shall bring some cases before you; but before they arrive I wish to speak of the diagnosis, the prognosis, and the treatment of external hemorrhoids.

From time immemorial piles have been classified as external and internal, and while that is the true classification, you may have, of course, some internal piles that are partly external, and per contra, some external that are partly internal. But at the same time, when you come to make the distinction, all you have to do is to return the protruding part, and if it goes beyond the sphincter you can safely say it is an internal pile. The difference, however, between the internal and external is very great; and yet you will meet with many cases of external piles that have been diagnosed as internal, and very often with cases in which no distinction has been made. It has simply been stated to the patient he has piles, leaving him to infer either internal or external; yet the treatment must be radically different.

Many causes are recognized as efficient in producing external hemorrhoids; thus, you may say that diarrhœa, constipation, dysentery, over-indulgence of the sexual appetite, too high living, sitting upon a cold seat, intemperance, may all cause this development.

External piles can be divided into two classes, and one division ought to be called simply "tabs of skin." The other is a little venous tumor. It is the bursting, likely, of a small vessel, and the blood has run into the tissues and coagulated. Now, whether it be true that this coagulation is simply in the tissues or in the vein itself is a matter of little importance, because the treatment is the same in either case.

Having met with this order of piles in its simple, uninflamed condition, you would naturally suppose that they do not amount to much, and you will be led into the error of prescribing some simple application and sending the patient

home. But if you see it when it is inflamed, and has grown to be as large as a walnut, likely (and everything coming in contact with it causing the patient pain), you will then see they can be a source of much annoyance ; and if you meet with them in this inflamed condition, the question at once arises, How are you going to treat them? Remember, I say in this *inflamed* condition ; because you are not called upon to treat a simple little tab of skin ; but it is when they become inflamed, and engorged, and angry looking. The only question then can be, Must you operate upon it when it is inflamed? Surgeons, of course, take the position, and very correctly so in the majority of cases, that no portion of the human economy ought to be cut or operated upon when inflamed. Is that true in reference to this affection? I think not ; though, before you would resort to the operation you can make some application to it, if you prefer, to quiet the irritability, and the best thing you can do is to bathe them with cold water. You will find this, gentlemen, always one of the best applications, in these cases, to relieve the irritation. Suppose that is not sufficient, however ; then what is the best application in addition to this? If you are consulted at your office, my advice to you is to simply apply belladonna and extract of opium, in equal parts, with the direction to the patient to apply it again the next day, after a thorough ablution in cold water. If they will follow these directions and repeat the same for two or three days, this inflammation will have disappeared from this external tab of skin.

Then you have relieved this suffering for the time being ; but have you cured the pile? No. This tab of skin is there, or this venous tumor has just been reduced to the size it was before the inflammation.

Now what are you to do? Well, gentlemen, I am glad to say, that the treatment of external hemorrhoids is very simple and very effectual. If it consists of a tab of skin, clip it off with a pair of curved scissors. You will find a great many patients who will object to the knife, but you can assure them there is no other hope for a cure.

After this operation, all that is necessary is to apply some persulphate of iron ; if there is much hemorrhage, dress it with a T-bandage, and let your patient go home. The only question that could come up, then, would be, Should you allow them to take exercise? You will find they will go about their business, as usual. If the hemorrhoid consists of a little coagulated-blood tumor, then I think it is advisable to either cut off this, as you would a tab of skin, or, with a bistoury, cut into it and evacuate the blood. If this has existed for a long time, or if there are any flaps of skin that can fall into this cut, with a pair of scissors cut them off.

This constitutes the treatment, and the only sensible treatment, for external hemorrhoids.

Case 1.—Now, I have told you that external hemorrhoids are liable to become inflamed. I will add, they are also liable to become ulcerated. You will find that as they exist they are liable to be rubbed by the clothing, or possibly there is a discharge from the bowel that, coming in contact with the tab of skin, will inflame it, and therefore there is considerable pain, not only in defecation, but also in walking or any other exercise.

This man says he had an attack of piles about ten years ago. Those were probably internal piles, which, ascending above the sphincter, never troubled him again, or one of these tabs of skin that has never since been inflamed. To-day he has them, not only inflamed, but ulcerated. When this inflammation has subsided they will be only about one-fifth their present size. Here, at another point, is one of these tabs of skin uninflamed. If it should become so, it would be much larger than this which is now inflamed. Here, bordering upon the perineum, is some superfluous skin that may become inflamed and give rise to the same amount of distress.

Now let us apply the treatment to this case. But first let me urge you never to be satisfied with the diagnosis of only one class of trouble, because if you do you may be guilty of operating upon external hemorrhoids when there exist at the same time internal. Besides, in a case like this you may have fissure, or a narrow fistula, or an ulceration, or a stricture of the rectum ; therefore we will proceed, by the introduction of a finger, to determine if anything else exists, more than is apparent externally. * * * These are simply external hemorrhoids. We will apply the belladonna and opium here for a day or two, and then the only sensible thing remaining to be done is to operate, and that operation consists in cutting them all off, because if you leave any they may become inflamed and give us much trouble again.

Now, here is one that is ulcerated. If you rely upon local applications to cure this, it would require three or four weeks to accomplish that result, while if you operate upon it at once you see the ulceration, being confined to the pile, is removed and the man is relieved of his hemorrhoid and the ulceration both at the same time. It is remarkable how readily these wounds heal. If you apply the persulphate of iron and put on a T-bandage he will be well in three or four days, and will suffer no relapse. It is not necessary even to confine his bowels, as we do in most cases of operations upon hemorrhoids, by some form of opium. It will be sufficient for him simply to bathe the parts and keep them clean, and this, gentlemen, constitutes a radical cure for hemorrhoids of this character.

I would not have you waste your time with these patients, applying ointment for weeks, when you can do this operation at your office and send your patient home not only relieved but absolutely cured.

Fistulæ.

Case 2.—This is the case of fistula that was operated upon by Dr. Ritter (Interne) three weeks ago. It has not healed as readily as it should. You all remember this was a large cut. involving the laying open of three fistulous tracts. There are several reasons why a wound of this character does not heal as kindly as you wish sometimes. In the first place it was a large cut ; in the second, it is a difficult matter to keep a patient of this kind in bed, inasmuch as they do not suffer much pain after the operation ; and if you will

but reflect a minute, you will see that unless you do, these parts are dependent, and the circulation bad; and beyond this you frequently find a diathesis that prevents the healing process. Such cases must be placed upon constitutional treatment, and unless you take that precaution you will, in this class of patients, frequently fail in your treatment. This, however, is now healing very nicely, and in a few days she will be entirely well.

In the healing of fistulous cuts, gentlemen, it is of prime importance for you to remember what I said about granulations. These wounds must heal from the bottom. You will find a tendency on their part to heal at the sides, and that must be prevented. Every day, as they are healing, pass your finger to the bottom of them, and break down the adhesions at the sides, thus compelling them to heal from the bottom.

There is another thing I would have you remember in the treatment of rectal affections in women. If you find, for instance, that a woman has a fistula, and desires it cured, you ought at the same time to examine the uterus, and if you find any retroversion or anteversion, you should refuse to operate. This is the rule, though I have violated it several times with success. But I think it is better to first refer her to the gynæcologist for treatment. The question will arise sometimes, shall you operate upon a woman who is pregnant? There are a certain class of rectal affections that will call for immediate operation. Suppose you have a capillary pile from which there is oozing constantly arterial blood. I have seen women so blanched and reduced that they could hardly walk across my office floor, from this loss of blood, and under these circumstances I would not hesitate to operate. True, it might cause an abortion in some cases, but if you take the precaution to confine your patients to bed there is not much danger.

These are questions that will come up in your practice, and it is well enough to refer to them now. I prefer to mention these points to-day rather than to enter upon the treatment proper of fistulæ which I will discuss in future clinics.

Pruritus Ani.

Case 3.—It is clearly to be seen that this woman has pruritus ani. We will see if there is any other trouble. * * * * * There is not.

As I told you the other day, when I presented a woman to the class suffering from this trouble, there is no class of rectal affections that causes so much distress as this particular thing. The distress comes, of course, in these instances, from the itching and scratching. The cause of it may be traced to many things. A slight inflammation here may be caused by the passage of hard fecal accumulations. The stretching of the sphincter ani is sufficient to cause this inflamed condition. It may arise from an ulcer within the rectum, the discharge from which coming in contact with the skin will cause irritation. It may arise, in adults as well as in children, from thread-worms, "oxyuris vermicularis;" it may be herpetic or eczematous, and come from a filthy condition of the parts.

In this case it is evidently of long standing. The skin around the anus, here, is hard, indurated, scabby, and directly it will peel off, leaving the part red and irritated. I prescribed an ointment of vaseline and calomel, with frequent applications of "yellow wash," and under this treatment the patient is getting better. Now it behooves us to be able to treat and cure this condition, but do not be surprised when I tell you that this affection, simple as it may seem, will resist for years all medication that you can use. And if you meet with these cases and prescribe for them, and fail to relieve them in a few weeks, they will seek some other aid.

This is a local affection, but if you find it resists all local applications, it will be necessary to place the individual on constitutional remedies, and one of the best is Fowler's solution, kept up until you get its effects, as manifested in the swelling of the eyelids, etc. Then stop it for a week, and commence again, at the same time using local applications, one of the best of which would be—

℞.	Iodoform,	gr. x	
	Acid carbol.,	gr. v	
	Vaseline,	℥j.	M.

Sig.—Apply ter die.

Another good application is hydrarg. mitis, gr. xx, vaseline, ℥j, made into an ointment and applied once or twice a day. Another is carbolized oil, applied in sufficient strength, say half a drachm to an ounce of glycerine or sweet oil, and if these do not give relief the application of sulphurous acid diluted in water and applied with a brush three or four times a day. This may be tried, if the trouble arise from parasitic causes, and while you are treating these patients locally and constitutionally you will have to keep the motions from the bowels soluble, and for that purpose I would use castor oil every day while under treatment. If they complain of this, you will find cascara sagrado, fluid ext., an excellent remedy. I can safely say I have met with no remedy so uniformly successful in relieving habitual constipation as this one. It does not act as a purgative at all, and sometimes you will have to give it for several days, a week or two, before you get its effects, but you will find it efficient in relieving some of the most obstinate cases of constipation. To relieve the terrible itching of which the patient complains, nothing is better than chloroform ointment (℥j to ℥j) applied at night.

Rectal Fissure.

Case 4.—Here is a woman who has had a rectal trouble, she says, for four months. She now has specific trouble, and is under treatment for the same. She says she has pain whenever she has an action of the bowels, and that this pain lasts about half an hour. She has no pain before she goes to stool. She has a discharge from the rectum, of blood and mucus. She has nothing to descend out of the bowel.

Whenever you get such a history and symptoms as these you can safely diagnose fissure of the rectum. These are its characteristics. She tells you that between the times that she goes to stool she suffers no pain, but she suffers during and following a passage. Do not, however, be satisfied with saying there is fissure, but

examine the case thoroughly, and whenever you find a patient with a syphilitic history, having a rectal trouble, look for ulceration, and if you find it place the patient at once upon anti-syphilitic treatment. Don't understand me as saying that all ulcerations found in the syphilitic patient are due to syphilis; but I do intend to say that the majority of such are. It is a question yet mooted, whether this ulceration found in the rectum, and due to syphilis, is a local manifestation of the constitutional trouble or has occurred by an extension of chancrous pus. The first of these I believe to be correct, and will take another time to give you my reasons for the belief.

You see this fissure is located just at the margin of the sphincter muscle. There is ulceration extending over this fissure, it does not surround the bowel entirely, and this is what gives rise to the discharge the patient complains of. Now, the treatment for this, to relieve the pain, is to do just one thing only. It would be useless to waste your time in giving this woman ointments or any local applications for this purpose. Cases the result of a specific cause, especially resist local applications, so in this case I will dilate the sphincter and placing the fissure-knife above the margin of the fissure I will draw it through the tissues and include, if necessary, the external sphincter muscle, and bring it out half an inch beyond the external border of the fissure. If you will make this incision the pain she speaks of will be well in an hour. I have seen patients who have suffered from this condition relieved in five minutes, of all pain, by the simple drawing of the knife through the tissues. After it is divided it is a good plan to make a local application to the remaining ulceration, and for this purpose iodoform, twenty grains to the ounce of vaseline, answers excellently well, and in connection with this I would syringe out the bowel with carbolized water once or twice a day. That will keep it clean and enable it to heal faster. This local treatment, in conjunction with the constitutional medication, must be kept up until you can pronounce the ulceration cured.

Ulceration of the Bowel.

Case 5.—Here is another case of specific trouble. This woman complains of the same kind of pain as did the last patient, but says it lasts only about fifteen minutes after defecation. She also has a discharge, but of blood and mucus mixed. The other said she had a discharge of pure blood sometimes, and you saw the cause —stretching of the sphincter muscle, drawing apart the fissured surface.

Externally, here, you find a bad condition of affairs. Fistulous tracts and ulceration, which extend very far above the sphincter. Knowing the history to be specific, we at once conclude that it is specific ulceration of the bowel.

Upon the introduction of the finger into the bowel, we find—what is the result of inflammatory action—the tissues are indurated and the part is denuded of its mucous membrane for several inches up. I also find a strictured surface. You see the great amount of pus that is now issuing from the anus. The examination causes the patient such pain, that I will desist and take occasion to put her under the influence of an anæsthetic and make a thorough examination. My time having now expired, that must be postponed until our next clinic.

Editorial Department.

Periscope.

The Therapeutic Uses of Hyoscyamine.

At a recent meeting of the Cambridge Medical Society, reported in the *Lancet*, July 10th, 1880, Dr. Bacon gave an account of the preparation known as "Hyoscyamine," and of its therapeutic uses. There are two preparations sold under that name, both made in Germany. One is Merk's "Extract of Hyoscyamine," and the other is a crystallized preparation in the form of a whitish powder and of variable strength. His experience has been limited as to Merk's extract. It is most conveniently administered dissolved in alcohol, one grain to the drachm. The solution mixes badly with water, a resin forming on the sides of the bottle. The preparation deteriorates by keeping; if it become greenish in color, it is a sign that its he.rength is lessened and that its action may not will elied on. It is called by the manufacturer ated. "extractive amorphous alkaloid" of hyos- "ab! s. and is very costly. With this prepa- ration he has found the effects much more potent, and more certain and reliable than those of ordinary henbane. Its action is that of a powerful sedative and hypnotic, and it is the only sedative and hypnotic in his experience whose action may be certainly relied on. Doses as large as two or three grains of (Merk's extract) have been administered; he had himself never given more than a grain and a quarter, and his usual prescription was three-quarters or one-half a grain. If three-quarters of a grain be given to a maniacal patient in a state of excitement, he will be reduced in half an hour to absolute helplessness, and will be probably asleep or comatose. The lips become red, the face dusky, and the saliva flows from the mouth; the pulse is quickened and there is dilatation of the pupil, lasting for twenty-four hours; the other symptoms pass off in about twelve hours. Vomiting had occurred in two or three of his cases. The drug is especially valuable in treating the maniacal condition (chronic or acute). It had been used in delirium tremens, and its power of inducing quietude and sleep to a certainty indicated its value in that condition. In some cases the beneficial results flowing indirectly from its use had been so great that he had been

able, after a time, to dispense with the drug. Two cases had occurred in his practice which would serve to show where caution was necessary. In the one (a private patient) only half the dose prescribed was given, and the patient, instead of being sent to sleep, was put into a state of excitement and delirium. In the other an accident, fortunately not fatal, followed the administration of the drug. The patient had become profoundly insensible, and had vomited, and part of the vomit (consisting mostly of partly digested bread) appeared to have got into the air passages, giving rise to corresponding symptoms.

Belladonna Poisoning Treated by Chloral.

Dr. Trocquart reports the following case in the *Journal de Médecine*, of Bordeaux :—

M. T., aged twenty-five, of a strong constitution, had suffered for some days with singing in the ears, for which somebody had recommended him to take belladonna. Patient, who was a dealer in pharmaceutical products and medicinal plants, took a pinch of belladonna leaves, which he infused in a small quantity of boiling water and administered to himself. About half an hour later he was seized with severe pain in the stomach, excitement and vertigo. He took some tartar emetic, which made him sick. I saw the patient three hours after he had taken the belladonna. He was in a state of violent delirium. Four people could with difficulty keep him in bed. He uttered piercing cries, and did not recognize any of his family. The face was red, animated, covered with sweat; the eyes haggard, pupils dilated; the entire body convulsed by disorderly movements. These attacks of furious delirium lasted four or five minutes, then the patient fell for some minutes into a state of complete prostration, which was soon succeeded by a fresh access of delirium. I recommended the patient to be closely watched, and his limbs restrained, so that he should not wound himself by throwing himself out of bed. I also ordered a draught of four grams of chloral.

When I saw him again, some hours later, I found it had been impossible to get him to open his mouth to take the draught; indeed, he had spat out a few drops which had been put between his lips during a calm moment. I then got them to give him an enema containing five grams of chloral. Calm soon succeeded to the violent attacks which I have mentioned; the patient fell into a sound sleep. As soon as agitation appeared we made him take a spoonful of the chloral draught. The night passed without accident, and the patient awoke in the morning suffering only from great muscular fatigue.

A "Credé" Method Among the Kiowa Indians—A Contribution to Obstetric Literature.

G. A. Moses, M.D., of St. Louis, states, in the St. Louis *Courier of Medicine and Collateral Science*, for July, 1880, that Dr. L. L. McCabe, Surgeon to an Indian Agency, related to him the following interesting fact in aboriginal obstetrics :—

An Indian woman, of the Kiowa tribe, one of the wildest tribes, which has come scarcely at all in contact with the whites, had been in labor for three days, and it being apparent to the friends and midwife squaw that successful natural delivery was impossible, and that under the native treatment by incantations, beating of tom toms, etc., the woman's strength was becoming rapidly exhausted, assistance of the Post medical officer was desired. It was only after several visits to the wigwam that the doctor finally was allowed to make a very hasty and imperfect digital touch. The head was arrested in the cavity. After still further delay he was permitted to apply the forceps, which, to the intense amazement of the lookers-on, drew forth a living infant. As soon as this was effected, the physician was rudely pushed aside, and the Indian midwife took charge of her case, compelling the woman to rise to her feet. She was sustained in a bent posture, grasping with both hands the centre-pole of the tent; then the squaw proceeded to carry out, methodically, Credé's method of expressing the placenta, by compressing the uterus through the abdominal walls, with both hands pressing in the direction of the pelvic cavity, until the placenta appeared at the vulva, when it was seized with one hand and withdrawn; the patient was then allowed to resume recumbency, and a highly ornamented buckskin bandage was adapted to pelvis and abdomen; this was drawn snugly by buckles and straps. The doctor says it looked as though it had been in use some time, and was a most perfect fitting bandage. The patient made a good recovery, and the white man's "iron hooks" are established in reputation among the band.

If the Indian mother gives birth to twins, only one is allowed to live. In case of the birth being male and female, the latter is delivered to an old squaw, and nothing further is heard of the luckless papoose. In case of both children being of the same sex, the feeblest is put out of the way.

Coca.

Concerning this remedy, which has lately been prominently before the profession, Dr. D. H. M'Donald, of Quincy, Ind., writes to the Louisville *Medical News*, July 17th, 1880 :—

There can be no question of the potency of coca, and in the hands of the intelligent physician much good may be expected from its use. But do take your trenchant pen and give us a slashing article against the indiscriminate use of it. You know a confirmed chewer of coca is called a coquero. Among the Spanish Americans a coquero is considered hopelessly lost, with no prospect of reformation. Look at the picture drawn by Von Tschudi: "The inveterate coquero is known at first glance. His unsteady gait, his yellow skin, his dim and sunken eyes encircled by a purple ring, his quivering lips, and his general apathy, all bear evidence of the baneful effects of the coca juice, when taken in excess."

Surely this picture is enough to startle any one: but I know that some cannot be startled if there is a prospect of satisfying an appetite; therefore the need of a warning in time, to the profession as well as the masses, against the indiscriminate use of a drug which is apt to be followed by the blasted life of the coquero.

Examination of the Œsophagus, Under Chloroform.

The following is an abstract of a contribution by Dr. Girard, of Berne, to the *Centralblatt für Chirurgie*, No. 21, 1880: Under certain conditions, it is found necessary to give chloroform in order that a bougie may be passed readily down the œsophagus. In the administration of this anæsthetic, the usual sitting and the half-recumbent positions are inconvenient, and in the former position chloroform is dangerous, and the passing of a bougie during anæsthesia may be attended with much difficulty. This difficulty may be overcome by placing the patient on an operating table with the body lying horizontally and the head projecting beyond the table's edge, where it should be supported by an assistant, in order that the cervical vertebræ may not be bent too much over the edge, and made so prominent as to prevent the introduction of the œsophageal bougie. The surgeon stands on the left side of the patient, and is now able to introduce the sound under the following favorable conditions. 1. The mouth is either found open, or can be opened without any difficulty. 2. The trunk, neck and head can be very readily fixed in the desirable position. 3. The buccal cavity, the pharynx, and the œsophagus are in a straight, or nearly straight, line, and a straight instrument, if not too thick, can be easily passed. The surgeon, holding the bougie in the supinated hand, passes it in a horizontal direction, with a movement like to that of the first step of urethral catheterism. The supination of the surgeon's hand, and the horizontal movement, allow a freer, readier, and more delicate introduction of the bougie than does the movement in a vertical direction, and so favors a close exploration of any obstruction or stricture. Dr. Girard reports that he has practiced this method in two cases with very satisfactory results. In one of these he had to deal with a carcinomatous stricture of the œsophagus, the coats of which were so sensitive that it was difficult to pass a bougie, save under chloroform. On the administration of this anæsthetic to the patient in the above described position, bougies of large size could be passed readily and precisely through the constricted portion of the canal. The second case was one of foreign body in the œsophagus. In conclusion Dr. Girard suggests that it may be possible to apply his method to the introduction into the œsophagus of instruments permitting an endoscopic examination.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Prof. C. J. Lundy, of Detroit, sends us, in a reprint from the *Michigan Medical News*, June 10th, 1880, a clinical lecture on "Diabetic Cataract, Iritis, etc.," and also a pamphlet on "Sympathetic Affections of the Eye," reprinted from *Leonard's Illustrated Medical Journal.*

——The first number of the *International Surgical Record*, a weekly journal, devoted entirely to Surgery, is before us. It is edited by A. Chilles Rose, M. D., who informs us that, besides articles from American authors, complete translations from foreign medical literature will also be published. The office of the journal is No. 1 Chambers street, N. Y. Subscription Five Dollars per annum.

——*The Atlantic Monthly* for August continues the "Stillwater Tragedy," by Thomas Bailey Aldrich; "Sicilian Hospitality" is depicted by Luigi Monti; Susan Coolidge contributes a poem, entitled, "Kintu;" "The Surgeon at the Field Hospital" brings to us memories of the late war; among other articles are: "Mr. Hunt's Teaching," by F. D. Willet; "Pepacton;" A Summer Voyage, by John Burroughs; "The Archbishop and Gil Blas," by Oliver Wendell Holmes; "Sylvia's Suitors," by Louise Stockton; "Among the Pueblos," by Susan A. Wallace; "Edward Mills and George Benton," by Mark Twain; "The Preceptor of Moses," by Francis H. Underwood; and several others of considerable interest.

BOOK NOTICES.

An Experimental Research on the Physiological Actions of Drugs on the Secretion of Bile. By William Rutherford, M.D., F.R.S., Professor of the Institutes of Medicine in the University of Edinburgh. With one hundred wood cuts. Edinburgh, Adam and Charles Black, 1880. Cloth, 8vo, pp. 173. Price $3.00.

This little work is the product of a series of carefully performed experiments, made for the purpose of ascertaining to what extent, if any, the various drugs which are administered for their cholagogue action actually influence the production of bile. These experiments were performed on dogs, that animal being selected because the size of its common bile-duct renders it possible to introduce a canula with an orifice sufficiently large to prevent its being blocked up by particles of inspissated mucus from the gall-bladder, and also for the reason that its digestion resembles that of man, inasmuch as its stomach is empty when the process is completed. More than fifty drugs were experimented with, and their effect on the bile-secreting function carefully noted. The results of these experiments, which are of incalculable value to medical science, were first published in the *Journal of Anatomy and Physiology*, and in the "*Transactions* of the Royal Society of Edinburgh," from which this book is reprinted.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE LEGALITY OF SANITARY MEASURES.

The love of liberty is so thoroughly taught to the citizens of this country, that it is a matter of serious doubt with many of them whether the care of the health of individuals properly forms a part of the functions of a government.

In times of epidemics, and in the face of contagious diseases this question becomes a vital one; and at all times the prevision and forethought necessary to protect the community are of little avail, unless supported by the strong arm of public authority. There are not a few diseases the reduction and prevention of which demand constant attention, to be successful. We may mention smallpox, yellow fever, syphilis, and leprosy, where they prevail, as examples. Compulsory vaccination and the enforced registration of prostitutes and examination of seamen are mooted questions, not on sanitary, but on politico-economical grounds. Is it consistent with a free government to enforce such measures? Does it not transcend the limits of legislative authority to pass such enactments?

If we examine this objection in the light of the most recent authorities we may reach a correct opinion. If we are governed merely by prejudice or ignorance, we may not.

President Woolsey, in his recent treatise on *Political Science* (vol. II, p. 398), defines the office of sanitary regulations to be to "prevent the introduction and spread of disease." He adds: "Here a very wide field is open, which can be properly taken care of by no association of medical men or philanthropists, but needs that public authority should be vested in some board or commission." In the accomplishment of these objects DR. WOOLSEY, recognizes that at times, as for instance in the control of the construction of tenement houses, there may be some decided interferences with an individual's employment of capital, or, as in quarantine, with his personal liberty. Yet he decidedly considers that it is the duty of the State to take such measures.

This opinion of the most eminent American writer on the principles of law coincides entirely with the verdict of the civilized nations of history. The sanitary regulations of the ancient Israelites, as preserved to us in the books of Moses, are marvelously minute and severe. In imperial Rome, a special branch of medical officers, the *archiatri populares*, were appointed to protect the public health, and clothed with ample authority for that purpose. In later centuries the barbarism of the Middle Ages, and at present a misunderstood theory of free government, have offered considerable opposition to the enforcement of general sanitary regulations. In the United States this narrow view has even found defenders among the regular profession. Witness the opposition which the organization of the National Board of Health encountered. It was alleged that its powers interfered with "State rights:" that the principles of our Government were endangered; that there was in this Board a seed of centralized power, etc.

So also the regulations attempted to be enforced against the spread of syphilis met opposition, not only from priests and women—classes

which, as Thackeray remarks, are always sure to ruin a country when they get control of its politics—but from some medical men of middling good position.

But, as respectable medical men are also found who have embraced homœopathy, favored phrenology, and even opposed vaccination, one can only explain such a phenomenon by believing that a medical man may be respectable and still have such a soft spot in his brain that he cannot tell sense from nonsense on the subjects which he has most studied. Fortunately, the number of such weak brethren is limited, and the probability is that it will become still more so as the general intelligence on these matters clears up, and the necessity for action becomes more apparent.

Notes and Comments.

Therapeutical Notes.

TREATMENT OF PERTUSSIS.

Dr. E. J. Beal, of Fort Worth, Texas, states, in the St. Louis *Clinical Record* for July, 1880, that he has successfully employed the following treatment in numerous cases:—

Three or four thicknesses of white flannel, four by four inches, are quilted together and suspended by tape around the neck of the little sufferer, like a necklace. The pad so formed is to be saturated three or four times daily with the following mixture, and to be worn night and day. When the child sleeps, the pad to be placed in close proximity to the respiratory outlets:—

℞.	Ol. sassafras,	ʒ iij
	Ol. terebinth,	ʒ iv
	Fl. ext. belladonnæ,	ʒ ss
	Phenol sodique,	ʒ iv.

If it is apprehended that the little sufferer will place the pad in the mouth, it would be well to be guarded in not exceeding the amount of belladonna suggested.

Epilepsy and Crime.

In *Brain*, quoted by London *Medical Record*, Dr. Clarke has published some very suggestive tables of statistics. He finds it hard to avoid the conclusion that alcoholism in the parents is a predisposing cause of crime and epilepsy. Forty-four per cent. of epileptic criminals were the children of drunken parents. With regard to the parents he finds that epilepsy is more frequent in the mother than in the father, and that the percentage for both parents is higher with the women than it is with the men. In drunkenness the reverse holds good. The proportion of epileptic and insane relatives is found to be very much greater with criminals than with ordinary epileptics. It has been asserted by Taquet that "sexual desires show themselves early in the children of drunkards, and are associated with absence of moral sense." The author finds that the convictions for bastardy are three times as numerous among epileptics as among non-epileptics—a fact which strongly bears out his idea that epilepsy owes its origin to hereditary alcoholism. Other tables show that the amount of crime as indicated by the number of convictions is greater among epileptics than among ordinary criminals.

The Treatment of Granulations in the Pharynx and Larynx by Ignipuncture.

Dr. Krishaber, in *Annales des Maladies de l'Oreille; du Larynx, etc.*, May 1880, gives a description of glandular pharyngo-laryngitis—its causes, pathology, symptoms, diagnosis, and finally its treatment. The part of the larynx most commonly affected is the mucous membrane of the arytenoid cartilages. The author has, however, seen distinct granulations on the vocal cords without any concomitant implication of the remainder of the larynx, or of the pharyngeal mucous membrane. The granulations produced by hypertrophied glands may, if isolated, pass unnoticed during life, unless a very powerful illumination be employed. This, according to the author, explains how it is that some observers deny the presence of granulations in the larynx. They are almost always of larger size in the pharynx. When the granulations in the larynx attain to a considerable size, they form true polypi, having the structure of adenoma. For destruction of the granulations, the author prefers the application of ignipuncture. When the granulations are situate in the pharynx, he uses for the purpose Paquelin's thermo-cautery, and when in the larynx the galvano-cautery. (The latter may, however, be used for both forms.) Three cases are cited, in which granulations in the larynx were treated by this method. In the first case, there were two large granulations in the anterior angle of the right vocal cord, one of which was removed by a single application of the cautery, the voice becoming perfectly clear. In the second case, both pharyngeal and laryngeal granulations were cauterized, with great improvement to the voice. In the third case, two large granulations, which

produced no inconvenience, were accidentally discovered on the free margin of the epiglottis, and removed by a single application of the galvano-cautery. A fourth case is also described, of a lady, suffering from pharyngo-laryngeal granulations, accompanied by a feeling of a foreign body in the throat, and a dry cough. Under treatment by ignipuncture, complete recovery ensued. The author considers that the danger in this method of treatment is much less than it seems; the normal laryngeal mucous membrane presenting a much greater resistance to cauterization than the morbid growths. The efficacy of this method is infinitely superior to that of other caustics. Of pharyngeal granulations treated by ignipuncture, the author has had more than forty cases. The number of applications required in these cases varies from five to twelve. In conclusion, the author states that this treatment of glandular pharyngo-laryngitis is almost painless, and is followed by no inconvenience, a result being very promptly obtained. It is easily applied, and, except in some rare cases, requires no special skill in its employment.

Ante-Mortem Rigor Mortis.

Mr. Alfred Finch, M.R.C.S., reports, in *The Lancet*, a case of a woman, sixty-five years of age, who had abstained from the use of all food for two weeks, while suffering from mental distress. In dressing one morning she observed a numbness of the legs, and on attempting to come down stairs all power of motion was lost. Examination showed entire absence of voluntary and reflex motion as well as sensation below a clearly defined line at Poupart's ligament, where also was a well marked difference in temperature, the surface above being warm and below cold and livid. There was also perfect muscular rigidity. Within two hours after death, which occured fourteen hours after the development of the symptoms just related, all muscular rigidity had disappeared.

Epileptic Amaurosis.

Dr. Christensen relates, in the *Ugeskrift for Läger*, second series, Band 27, the case of a married lady, aged thirty-three, of healthy family, who, since her first menstruation, in her twelfth year, had had attacks of loss of consciousness, sometimes with convulsions, followed by blindness of several hours' duration. These attacks occurred at each menstrual period, and ceased with the appearance of the catamenia. From her eighteenth year the convulsions became more severe, but the sensory impairment grew more rare and weaker. In December, 1872, the convulsions and catamenia did not occur; but after several days' headache and giddiness, she became blind in the course of an hour. The fundus of the eye was normal. Under the use of leeches and counter-irritants the headache ceased. Some days afterward she had an epileptic attack, in which there was considerable hyperæmia of the optic disc and retina. She menstruated in January, and her sight began to return. After some months her vision was $=\frac{1}{2}$, with blindness to red; the disc was somewhat atrophied. Four years later she had a similar attack of blindness, but not complete. Vision returned after the appearance of the menses, but again failed, and progressive atrophy of the optic nerve now commenced. The author believes the most probable proximate cause to have been hyperæmia or inflammation of the optic nerve behind the bulb.

The Effect upon the Heart of Preceding Inhibition.

Dr. Brown-Séquard has, according to the *Lancet*, July 10th, 1880, made a large number of experiments upon rabbits and young cats, on the effect of inhibition on the action of the heart. After the introduction of a tube into the trachea he insufflated the lungs in two rabbits at the same time. He opened the thorax, divided the pericardium, and ascertained the frequency and force of the heart's action. In one of the animals, that in which the heart was beating with least force, he galvanized the right vagus or both vagus nerves. Usually, after a variable time, the heart stopped. (Faradization of the vagus does not, in the rabbit, always arrest the heart.) When it recommenced to beat, he divided the two great arterial trunks which spring from it, in both animals, and then observed the action of the two hearts. That which had been inhibited always contracted much more frequently than that which had not. In five rabbits, for instance, in which there had been no inhibition, 1869 contractions were subsequently observed; and in five others which had been inhibited, the number of contractions was 3240. Moreover, the contractions were much stronger in the hearts which had been inhibited, than in the others. In one of the latter, during half the time of the observation, the contractions were confined to the right ventricle. In seven or eight minutes the hearts ceased to beat, but in two cases the contractions continued longer in the hearts which had been inhibited

than in those which had not. In three others the cessation in the two conditions was simultaneous. In the cats the same difference was observed. The contractions, after inhibition, were 292, as compared with 141 without inhibition. Should this effect be ascribed to the better nourishment of the heart during the period of nutrition? Dr. Brown-Séquard believes not, but promises another communication on the subject.

The Condition of the Uterine Mucous Membrane during Menstruation.

Dr. Moericke points out, in *Centralblatt für Gynäkologie*, June 19th, 1880, that menstruation is a physiological process. If the general theory that the mucous membrane of the uterus is partially or completely destroyed during menstruation were true, it would no longer be a physiological but a pathological process. Further, even in certain diseases of the endometrium, we find that the epithelial coating is retained. He thinks that the theory of degeneration of the mucous membrane at the menstrual periods arose from the fact that the preparations examined were not fresh, but exhibited *post-mortem* changes. The method which Dr. Moericke has adopted is to scoop off with a sharp curette a fresh piece of mucous membrane from the uterine surface. This he does at all stages of menstruation, before, during and after. In every case, both in the fresh and the hardened preparations, he has found the epithelial covering completely preserved. In some cases it was found to be ruptured or perforated by an underlying blood-extravasation, but in no place was it degenerating.

Nutritive Enemata.

Dr. Michelacci contributes an article on the subject of nutritive enemata, in *Lo Sperimentale*, June, 1880, in which he lays down the following general propositions. It is important to prepare the large intestine for the reception of nutrition by a previous injection of some simple substance. Whatever be the nature of the nutritive enema used, it should never be at a lower temperature than 37° or 38° Cent. (98.6° or 100.4° Fahr.). It is, as a rule, preferable to give a considerable number of small enemata rather than a few large ones. The injection should be administered slowly and cautiously, and conveyed as high up as possible, by means of a long tube. Each nutritive enema should be preceded by one of about two ounces of water, containing from four to eight drops of laudanum, in order to render the intestine more tolerant. In a clyster, alcohol should never be joined with peptone, as they are chemically incompatible. Fatty substances should be used sparingly, as they are difficult of absorption, and irritate the mucous membrane. Neutral or slightly alkaline enemata are frequently useful. In cases in which symptoms of irritation or enteritis supervene, the author recommends suspending the use of all further enemata, or, if this be not possible, then using opium freely, and selecting for injection only the less irritating substances.

The Treatment of Diphtheria.

Dr. Bloch states, in *La France Médicale*, that he has long employed as his principal treatment in diptheritic angina, dry cubeb pepper, applied to the throat by means of a brush, and has obtained from it excellent results. He orders the application to be made every hour, with the administration of liquid food, wine, bark, etc. The false membranes are detached and not reproduced. The application causes retching—sometimes vomiting.

These contractions of the pharynx are probably one of the elements of success. The absorption of the cubebs which the patients swallow also acts; this remedy has long been administered internally in membranous angina, and with satisfactory results. Lastly, the topical substitutive action has an important part in the happy effect of this treatment. It is easily used, and parents can themselves apply it to their children's throats. In catarrhal and pultaceous angina the same treatment succeeds marvelously—much better than alum, chlorate of potash, borax, tannin, etc.

The Normal Condition of the Eustachian Tubes.

We learn from the *Medical Press and Circular*, July 7th, 1880, at a recent meeting of the *Société de Biologie*, of Paris, M. Gellé expressed the opinion, the opposite of that recently put forward by M. Fournier, that in the normal state the Eustachian tube is closed. He gives the following reasons based on his experiments: If the tube is open a vibrating tuning-fork placed in the mouth should be heard even when the ears are closed. Now that is not the case. It is, nevertheless, possible to hear by the tube when the ears are closed, but only in cases where by a swallowing movement the tubes are opened. Hartmann found that to overcome the closure of the tube, and permit the air to penetrate to the tympanum, a pressure equal to from twenty to forty millimeters of mercury was

necessary. M. Gellé has found that from thirty to forty millimeters are required.

Correspondence.

A Case of Malignant Tumor of the Axillary Space, with Post-mortem Examination.

Ed. Med. and Surg. Reporter:—

On April, 23d, 1880, I was called to see Harvey A. Bushnell, aged 28; occupation, laborer; native of the United States, and married. Found him suffering with some diarrhœa, a dry, harassing cough, and some pain in his chest, on the left side, and apparently limited to the boundaries of the lower lobe of the lung on that side. At this time I noticed an immense tumor occupying the left axillary space, so large as to materially interfere with a careful physical examination of the chest. The following day, April 24th, I visited him again; found him more comfortable. At this visit he desired an opinion as to what was best to do with regard to the tumor. At this time the tumor measured about twenty inches in circumference, skin natural, except slight enlargement of the cutaneous veins, a peculiar, doughy, inelastic feel, not painful, and but slightly movable. He informed me that it had been eight years in reaching its present size, but there had been periods of activity and periods of rest in the time; and upon careful inquiry I learned that it had acquired its size mainly during two periods of activity, and that about one-half of the eight years was given to active growth and one-half to nearly, if not quite absolute rest. I advised him to go to prominent and experienced surgeons, and if agreeable with their advice and opinion, have it removed.

I did not again see the patient until May 29th, when he called at my office and requested me to accompany him to the city. Accordingly, on the first day of June I took him to the Long Island College Hospital, and placed him under the direction of Prof. J. S. Wight, of that institution. On the ninth day of June he returned home, and informed me that Prof. Wight, after the most rigid and careful examination, did not deem it prudent to attempt the removal of the tumor. The tumor now measured twenty-four inches in circumference and was rapidly increasing in size. The patient was now wasting rapidly, and in a few days after his return his cough grew worse, breathing became more and more difficult, and there began to be œdema of the feet.

About this time I found that over the region of the left lung the evidences of solidity became more and more distinctly marked. I also heard a peculiar cardiac murmur, which I had never heard before, and which I could not define.

Placing the stethoscope over the right side of the heart, it could be distinctly heard, resembling the bubbling sound produced by a fluid mixed with air passing through a tube. This sound was both systolic and diastolic, and it grew more and more distinct, and in proportion the dyspnœa became more oppressive, and the œdema of the feet increased.

Death took place early on the morning of July 16th, so suddenly, and so quietly as not seeming to rouse him from a quiet slumber.

At the autopsy I removed the axillary tumor, which weighed 9¾ lbs. and measured 27 inches in circumference. It had insinuated itself around the muscles and tendons approaching the shoulder joint, to some of which it was very firmly attached. It had extended itself entirely around the joint, and upward in front, underneath the clavicle. On section it presented the appearance of brain substance, except that it was not quite so white, very soft, and seemed to have formed in nodules, about the size of a pigeon's egg, the whole inner part being composed of this soft material, while their size and shape were preserved by interlacing bands of connective tissue. A few of these round masses were composed almost entirely of fat; and a few of chalky material. Opening the thorax, I found the left lung transformed into a mass resembling the tumor, only that it was harder and contained a greater quantity of chalky deposit. The heart slightly enlarged, and suspended by a pedicle half an inch in length, I found a growth the size of a small cherry, and attached to the margin of the tricuspid valve. I have this little growth in alcohol, and find that it begins to grow somewhat less, due, perhaps, to the solubility of the fat which it contains.

The liver was very large but not otherwise altered. Spleen the same. Mesenteric glands very much enlarged.

Under the microscope this large tumor presents both large and small round cells in great abundance, the multinucleated cells quite abundant, but the small round cells predominate. A few caudate bodies are seen.

The case excited no little interest here, and therefore I thought it might be of interest to the profession generally. As regards a diagnosis, I will only say that it seems to resemble sarcoma, of the medullary variety, while it presents some of the characteristics of encephaloid

Stephensbury, N. J. E. P. Iliff, M. D.

Sanguis Bovinus Exsiccatus.

Ed. Med. and Surg. Reporter:

In reply to numerous queries received from the profession, regarding the results obtained from the use of defibrinated blood, I have to reply as follows: Although this agent is but a recent introduction to therapeutics, it is already extensively employed, especially in hospital practice. Sufficient time has not elapsed, however, to determine its true therapeutic position, as only the accumulated results of experience and observation are to be depended upon as scientific evidence. Until, therefore, the accumulated evidence from the evolution of time can be obtained, it is impossible to furnish the profession with a truly scientific history.

The desiccated product suggested in my article, published in the "*Medical Record*" some months ago, was intended to utilize what then appeared a valuable product, and reports from hospital trial seem to fully justify the belief that it posesses important therapeutic value. Beneficial results usually follow its adminis-

tration, though in some instances results have not realized expectations. But as many have reported a success above anticipation, it is only fair to charge such failures to a fault in the expectation, rather than to the article in question. The immense sale would seem to be an argument in favor of its value, except for the fact that valueless articles have had an immense sale; still this will probably result in proving what worth to set upon it the quicker. The history of every new drug has been that of great popularity at first, a disappointment of hopes, followed by condemnation and rejection; but finally inherent merit has in most cases been recognized, followed by a healthy reaction. Such a history can always be traced to expectations exceeding reality, either on the part of the introducer or advocates of the use of the drug; instance, salicylic acid, etc.

To fix the position of defibrinated blood as a therapeutic agent, and especially that of desiccated blood, as soon as possible, it has been placed very extensively in the hospitals of New York, Philadelphia and Boston, and in the hands of careful and competent observers, for thorough and scientific test. As soon as reports are received from these institutions they will be furnished to the profession, through the columns of the medical press, and it is hoped that in this manner information can be quickly gleaned which shall show to what extent defibrinated blood can be relied upon in the treatment of disease.

For the convenience of those now employing the blood in practice, the experience of the New York City Hospital will be of use. In this hospital the desiccated article, dissolved in water, and with the addition of brandy and glycerine, is now employed. For this mixture the following is the formula: Desiccated blood, 6 drachms, dissolved in water, four fluid ounces, to which add one ounce each of brandy and glycerine. Of this solution the dose has been determined by the case. A teaspoonful every fifteen minutes is sometimes given, but the dose of a tablespoonful every three hours is usually preferred. A greater quantity at first is not readily digested by the stomach. This mixture is readily retained, even by the most delicate stomach, though other flavor has occasionally been added.

Per rectum, a mixture prepared from the same formula meets with favor, though but little difference is observed upon the omission of the brandy and glycerine, and a substitution of water in its place. Here, as by stomach, the idea has been to put as much blood inside of the patient as possible, in the shortest time. But it is found that more than three ounces injected every three or four hours is not advisable.

In the New York Hospital defibrinated blood is used, both as a sustaining and supporting measure, and also as a restorative agent. Its use is not confined to any one class of cases, but upon the same indications as meat. Patients to whom it is given have received much benefit from it, in some instances, while in others the results are not so marked.

Still more favorable reports are received from St. Francis' Hospital, New York, and Ward's Island. At each place is to be found the history of a patient whose life has been apparently saved by defibrinated blood, after the failure of all other means, and a refusal of the operation of amputation.

In some instances a disagreeable odor has been imparted to the fæces during the administration of defibrinated blood, either when employed for rectal alimentation or when given by mouth. This is generally because a greater quantity than can be assimilated is given at one time, and it can usually be readily corrected by diminishing and properly regulating the dose. In these cases no ill effect has been observed—at least, to my knowledge—and a continuance of the medication has resulted beneficially.

New York. F. E. Stewart, ph. g., m.d.

Prolonged Fasting.

Ed. Med. and Surg. Reporter:—

The fast of Dr. Tanner recalls a singular case of abstinence that occurred in 1866, between May 19th and July 9th. I quote verbatim from notes taken at the bedside at the time:—

Mrs. Campbell, aged 66 years, widowed, of spare habit, living in Park Township, St. John County, in the family of David Hinebauch, has long been in feeble condition, sometimes with derangement of mental faculties, and for a long time having diarrhœa, from which last she had recovered.

Thursday, May 17th, she complained; Friday, May 18th, was worse; Saturday, 19th, she ate a light breakfast and went to bed, and at this time articulation became more and more difficult, until she could only say "yes" and "no."

On Tuesday, 22d, the right side was observed to be palsied, and so remained.

She took only water, firmly closing her teeth against everything else.

On Saturday, 21st, she ate two crackers, with water. After this she would not take anything, even water, until Saturday, June 23d, she took four or five spoonfuls of chicken broth and no more.

On Thursday, 28th, she became pulseless and cold, colder on the side not palsied, and so remained until Sunday, 30th.

On Thursday, 5th July, her bowels moved twice, and she began to eat and take medicine. but seemed to fail all the faster.

I saw her again on the 9th. Countenance cadaverous, pulse scarcely perceptible.

Subsultus.—She died on the 9th of July, having lived since her breakfast on May 19th, fifty-two days, forty-eight of which were without food of any kind except three crackers and five spoonfuls of chicken broth.

Her partial paralysis, her lethargic and semi-comatose condition, no doubt retarded waste of tissue and vitality, and seemed to simulate the condition of hibernation.

Mendon, Mich. Edwin Stewart, m.d.

A telegram to one of our *Dailies* reports fifty-one deaths from yellow fever and thirteen from smallpox in Havana during the week ended July 31st.

News and Miscellany.

Astrological Pathology.

It appears, says the *Lancet*, July 10th, 1880, that the planets Jupiter, Saturn, Uranus, and Neptune will be in perihelion simultaneously in the fall of the year. This, we are told, has not happened before for more than 1800 years. Moreover, the "star of Bethlehem" will again make its appearance in the eastern horizon in the month of August. These celestial events will mark the completion of one great cycle of 1800 years and the beginning of another; and we are warned that the first decennium of this coming cycle will be ushered in by disastrous outbreaks of pestilence—a veritable saturnalia of death. We are to anticipate, it seems, a recurrence of the terrible pestilences which concurred with the earlier years of the Christian era, and of which the recent irruptions of plague are alleged to be the forerunners. The astrological forecaster is an Irishman, and it is gratifying to learn that Ireland will probably suffer less from the evils presaged by this portentous conjunction of planets than other lands. Indeed, he anticipates that, knowing this, strangers will flock for safety to Ireland, and by the encouragement thus given to the commerce of the island help to raise her out of the unfortunate slough of distress in which she now finds herself.

A Cure for Snake Bite.

Mr. Tremlett, Consul for Saigon, furnishes, according to the *Medical Press and Circular*, July 7th, 1880, some further notes respecting *hwang-nao*, which is said to cure the bite of the most venomous serpents, and has been successfully employed in curing cancer, and principally leprosy, in the treatment of which it has never given other than satisfactory results. The native physicians, Mr. Tremlett tells us, distinguish thirty-six kinds of leprosy, the most common attacking the feet and hands; it is considered to be hereditary, and is usually contracted by children at the age of puberty. After some generations, it has been noticed to confine itself to either the male or the female members of the family; the disease is considered contagious, which only would account for the number of lepers in Tonking.

Personal.

—John J. Reese, M.D., Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania, has been appointed Coroner's Physician.

—Prof. Gross has, at the earnest solicitation of many of his friends, gone to attend the Annual Meeting of the British Medical Association, in August at Cambridge. It is generally understood that Cambridge University will duly improve this opportunity, and confer upon our distinguished professor the title of Doctor of Laws; so that when he returns he will be LL.D., Cantab., as well as D.C.L., Oxon,

—Professor Wallace is also in Europe, for his health.

The Medical Profession in Japan.

According to the *Pacific Medical and Surgical Journal*, for July, 1880, the total number of physicians in Japan, in 1877, was 31,268, two-thirds of whom followed the Chinese system. The "Western" or regular practice was followed by 6600, of whom 200 had been qualified by examination, and upward of 4000 followed a mixed system. At the same date there were upward of 150 hospitals of all descriptions.

A sanitary bureau, which was established in 1873, has been in active and useful operation ever since.

Dr. Tanner's Fast.

At noon, August 3d, Dr. Tanner had completed his thirty-sixth day of living without food. His weight has now been reduced to 125½ pounds, and although he is every day growing more feeble, the general opinion now is that he will hold out the remaining four days. It is, however, a question whether getting over his fast may not prove a more difficult task than going through with it.

QUERIES AND REPLIES.

In reply to Dr. J. M. B.'s query with regard to the best treatment for orchitis, Dr. J. F. Duran, of Quincy, Ill., recommends the following, used as a wet compress:

℞.	Ammon. muriatis,	ʒss	
	Fl. ext. humuli,	ʒj	
	Aquæ,	ʒvij.	M.

Dr. F. R. Millard, of San Diego, Cal., says that if the case be gonorrhœal, the lancet should be used, or, if this be objected to, the scrotum should be thoroughly cauterized with nitrate of silver, until the tenderness has disappeared, when strapping will complete the cure.

Dr. H., of Pa., asks for the best treatment of *bunyons*.

Dr. A., of Miss., requests information as to the best treatment of *granular lids*, the patient being an otherwise healthy boy seven years old.

Ans.—We have found a saturated solution of sulphate of copper, applied thoroughly with a camel-hair brush, twice daily, to be a never-failing remedy; it acts better than the solid crystal so much in use.

MARRIAGES.

BARDIN—LEDNUM.—On July 20th, by Bishop Henry W. Warren, Almon Z. Bardin, M.D., and Annie M. Lednum, all of Philadelphia.

HART—GILBERT.—In this city, on the 27th inst., by the Rev. C. M. Wines, E. Stanley Hart and Jennie Stillé, daughter of the late William Kent Gilbert, M.D.

DEATHS.

BELCHER.—At City, Dutchess County, N. Y., on Sunday, July 25th, Dr. William N. Belcher, in the 83d year of his age.

BRUNER.—At Shippensburg, Pa., July 10th, Clari S., only child of Dr. W. S., and Clarinda L. Bruner, aged three months and fourteen days.

GRAVES.—At his residence in Long Island City, on Monday morning, July 26th, after a brief illness, Dr. Lewis Graves, in the 70th year of his age.

HEBERTON.—At Mt. Desert, Maine, July 25th, 1880, Dr. G. Craig Heberton, in his 58th year.

HERING.—In this city, on Friday, 23d inst., Dr. Constantine Hering, in the 81st year of his age.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1224.] PHILADELPHIA, AUGUST 14, 1880. [Vol. XLIII.—No. 7.

Original Department.

Lecture.

VI. PULMONARY PHTHISIS.

Delivered at the Philadelphia Hospital, December 24th, 1879,

BY WM. PEPPER, M.D.,

One of the Physicians to the Hospital, and Professor of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WM. H. MORRISON, M.D.

Gentlemen :—At the last lecture I called your attention to hæmoptysis, its significance, and the conditions under which it occurs. I told you that in certain cases hemorrhage is the initial cause of phthisis. This relation of hemorrhage to phthisis has, of late, been considered pretty frequent, but I think that it is rather rare; much more frequently, in my experience, hemorrhage occurring early has been a symptom of an acute congestion or catarrhal pneumonia, and could not be regarded as the direct cause of the lesions that followed. It is only when we have hemorrhage occurring in a person whose lungs have previously been perfectly healthy, followed by catarrhal pneumonia, cheesy degeneration and phthisis, that we can regard it as the starting point of the disease.

Now, as to the treatment of this complication. Something will depend upon the condition of the patient and the state of the lung. As regards drugs, I do not know anything more difficult than to estimate the value of remedies in hæmoptysis. The hemorrhage frequently stops spontaneously. There are certain things to be done in the treatment of all cases. In the first attack you rarely have time to make an accurate diagnosis as to the condition of the lung and the exact seat of hemorrhage. You must first try to arrest the hemorrhage, and then determine the condition of the lung. An essential element of the treatment is absolute and perfect rest in bed, avoidance of talking, and the suppression of cough as far as possible. Then, everything which renders respiration easier should be encouraged. Nothing should obstruct the neck and chest. The room should be cool, the head and shoulders elevated, and the patient should swallow little pieces of ice. I think that the cold exercises some influence in checking the hemorrhage. All the nourishment should be cold and non-stimulating; as, for instance, cold milk and meat broths. We will see later that the debility of the system is sometimes so great that we have to resort to stimulants in order to maintain the circulation. As to the local application of cold to the outside of the chest, I do not think that this is advisable. It is probably true that if we could localize the seat of the hemorrhage, and if it was superficial, the cold pack might aid in checking it, but I think that the risk of the bad effects from the cold would be too great. I would prefer to resort to dry cupping over the back and front of the chest, over the spot from which the blood comes, if this can be located; but where you cannot locate the exact seat, a dozen dry cups may be applied over the back and front of the chest, if it can be done without disturbing the patient too much.

Of drugs, ergot seems to be the most powerful in checking hæmoptysis. The extractum ergotæ fluid. may be given in doses of a teaspoonful every fifteen minutes, until the hemorrhage is stopped, and then continued in smaller doses, or it may be given by hypodermic injection, in doses of

gtt xv, or ergotine may be used. If the stomach is irritable, gr. v of ergotine may be given, per rectum. Sometimes ergot will have no appreciable effect. Under such circumstances I think that gallic acid is the next best remedy. I frequently combine it with aromatic sulphuric acid, which makes a more efficient and pleasant mixture:—

℞. Acidi gallici, ℥ij
Acidi sulphurici aromat., f. ℥j
Glycerinæ, f. ℥j
Aquæ, q. s. ut ft. f. ℥vj. M.
Sig.—A tablespoonful, as required.

This is to be given every hour, every half-hour, or at shorter intervals, until the hemorrhage is brought under control. This, I think, ranks next to ergot, and where the stomach refuses ergot, or where ergot produces no effect, I usually resort to this combination.

You will observe that, so far, I have made no mention of the use of opium, which should be given to control the cough, quiet nervous irritability and allay vascular excitability. The opium may be given, either by suppository, by hypodermic injection of morphia, or the deodorized tincture may be added to the ergot or gallic acid combination. I prefer the use of opium to that of morphia in the condition I am now describing. For internal use, I think there is no preparation of opium equal to the deodorized tincture, the tinctura opii deodorata. Where the stomach is irritable, suppositories of opium or hypodermic injection of morphia may be used. The amount must be determined by the effects, but patients with hemorrhage will bear large quantities of opium. The proper method is to give small doses frequently repeated, until the desired effect is produced.

Sometimes the patient passes into a state of obstinate bleeding, lasting, not for an hour or two, but for several days, with evidence of severe congestion of some portion of the lung; and you may find that ergot, gallic acid and aromatic sulphuric acid fail to check it; we then come to the mineral astringents; of these, I think the best is acetate of lead, and next sulphate of copper. These should be given in pill form, with opium; but I do not think that they are so useful for producing an immediate effect as ergot and gallic acid.

Suppose we are able to tell where the hemorrhage comes from. Take a patient who has been healthy, has had no cough, no evidence of lung trouble; he begins to spit blood, but this is checked, in great part, by one of the means already mentioned; still it continues in small quantity; an examination of the lung reveals no solidification, no râles, no evidence of any disease; here we must conclude that the hemorrhage has, in all probability, come from the bronchial mucous membrane. In such a case astringent inhalations are very useful. They may consist of solutions of Monsel's salt, tannic acid or other astringent, which, by being forcibly drawn in, may reach the seat of hemorrhage. In cases where the hæmoptysis is due to an acute congestion of the vesicular structure, or to an acute catarrhal pneumonia, you will find inhalations of no material service. I doubt if they get far enough down to affect the bleeding spot.

I have spoken of derivation by dry cupping: this I think is an exceedingly important mode of treatment, and it becomes more important in proportion as you are able to localize the seat of hemorrhage, and to determine that it comes from a congestion of some portion of the lung, or from the seat of a catarrhal pneumonia. In such cases, I think that local depletion by dry cupping, or if there is a high degree of vascular excitement, with fever, and if the patient is strong, by wet cupping, is an exceedingly valuable means of arresting the hemorrhage.

Sometimes a patient with hæmoptysis, either from a previous weakening of the system by phthisis, or from the excessive amount of blood lost, or else from the severity of the local disease with which he has been attacked, falls into a very weak state, with rapid, shallow breathing, a rapid, feeble pulse and marked muscular prostration. Bleeding, under these circumstances, becomes dangerous, and occasionally we find a continual oozing of blood, which may even go on to a fatal result. Here we have to treat not only the hemorrhage, but also the constitutional condition of the patient, which verges on to the typhoid state. This condition often occurs in severe pulmonary congestion, where the system has been run down, or where the congestion involves a large part of the lung and is attended with this hemorrhage. In these cases the patient's strength must be supported by quinia, given freely. In order to avoid irritating the stomach, it is sometimes better to give the quinia by suppository. This drug also acts as an astringent by increasing the tone of the vessels. Digitalis, which acts in a similar manner, should also be given. It may be given in the form of the tincture or the infusion associated with astringents by the mouth. If I found that the appetite had disappeared, that the tongue was foul and coated, and that sordes had begun to form on the

teeth, I would associate turpentine with the quinia and digitalis, in place of other astringents. In this low condition turpentine is a valuable remedy, both for its hæmostatic power and for its influence over the typhoid state. I have met with cases where quinia, digitalis, turpentine, good nourishment, and a moderate amount of alcoholic stimulus carried the patient through an attack of hemorrhage, where I am sure an attempt to keep up the use of astringents or to use stronger ones would have resulted in death.

Finally, in those cases in which hemorrhage takes place from a cavity, owing to the ulceration or rupture of a blood vessel, our treatment has, I think, little or no power to arrest the bleeding, for if the vessel is large and the opening is free, the patient will die; but if the opening is small or valvular, the bleeding may stop spontaneously; but I do not think that we have any means of arresting such hemorrhage. Possibly, astringent inhalations might reach the part and thus favor coagulation of the blood, but at the time of hemorrhage they can scarcely be used. I have suggested, but never tried the operation of introducing the needle of a hypodermic syringe directly into the part and injecting some astringent solution. This, I think, would be attended with risk, and as I think the general proposition I have just made holds good, *i. e.*, if the opening is large the patient will die, and if it is small the bleeding may stop spontaneously, the treatment I would recommend is to sustain the patient's strength, keep him perfectly quiet and administer opium.

Even where we have a cavity, we cannot be sure that the hemorrhage comes from the rupture of a vessel, and so we should not neglect the use of other astringents, for it is quite possible that the hæmoptysis is due to a fresh attack of catarrhal pneumonia, or an acute congestion of the surrounding tissue. It is only where there is a large amount of florid, arterial blood, not mixed with air bubbles, thrown off, that we can be sure that it comes from the rupture of a vessel of considerable size.

The next complication to which I shall ask your attention is diarrhœa. Several of our patients have presented this symptom. It has been quite marked in the man before you, who has also a little hæmoptysis, probably the result of a slight acute congestion, from exposure. Diarrhœa occurs in a great many cases of chronic phthisis. In some it becomes so troublesome that it forms a most serious complication, and may even be a cause of death. This used to be described under the head of tuberculous diarrhœa, and frequently you will see the statement that diarrhœa occurring in a patient with phthisis is very significant of the development of tubercle. This is a very imperfect and partial expression of the truth, the real fact being, that the relations of diarrhœa to phthisis are by no means simple, and that the same mistake has been made in regard to the condition of the gastro-intestinal mucous membrane that has been made as to the condition of the lung in phthisis. We may say, at once, that any patient with centres of cheesy degeneration and disintegration of the lung structure is liable to have his system infected and get tubercle, and that the eruption of tubercle may occur either in the lung or in some other organ, and among the other organs which may be affected stands, perhaps not first, but among the first, the mucous membrane of the bowel, particularly its follicular structure; so that patients who have true tubercles forming in the course of phthisis are in danger of having intestinal tubercles develop, and under such circumstances there will be tubercular ulcers in the intestines, causing a diarrhœa of an intractable and incurable character. Such diarrhœa comes on, as a rule, very late in the course of the case, and does not long precede death, since not only will there be tuberculosis of the intestinal mucous membrane, but also tuberculosis of the lung, and probably of other organs. The whole system is involved, the whole nutrition is impaired, and therefore it is that such diarrhœa cannot long precede death.

But far more frequently the diarrhœa is of a catarrhal nature, and depends on the same weakness of system and want of proper tone of the skin upon which the attack of pulmonary congestion, or catarrhal pneumonia has depended. So that a patient who is in this state, after he has had a local lesion of his lung developed, and whose cutaneous circulation is checked, may have produced an increased congestion of his lung; or it may affect the throat, or larynx, or the intestinal mucous membrane; and the same want of tone and want of reaction that makes the lung trouble run a chronic course makes this congestion of the mucous membrane obstinate and apt to leave behind catarrhal thickening of the membrane and enlargement of the follicles. So that such attacks occurring in phthisical patients do not tend to pass on to recovery, as they do in healthy subjects. In some cases you will find repeated attacks of this kind occurring; and that, after you have checked the diarrhœa by means of dietetic and other treatment, the attacks recur every couple

of weeks, last a day or two, and then die away, to come back on the slightest provocation. There is not, in such cases, as is often said, repeated attacks of tubercles in the bowels. In these cases the diarrhœa is often regarded as due to an incurable lesion, and the proper treatment is not employed. What we really have is a chronic follicular catarrh, with thickening of the mucous membrane; these follicles may ulcerate, and the mucous membrane be covered all over with little round or oval ulcers, but not a single tubercle may be found. This, I say, is by far the most frequent relation of diarrhœa to phthisis.

We have seen that when a patient who has a marked tuberculous diathesis has ulceration of his lung, he is apt to absorb septic matter, and get a general tuberculosis; now, if this is true in regard to the lung, it is also true of the gastro-intestinal mucous membrane, and so we may have following these ulcers of the intestine tuberculosis of the membrane. You may examine the lungs, and find all the lesions of chronic destructive catarrhal pneumonia, but no miliary tubercle, while in the intestine there are found numerous ulcers with tubercles developed around them.

The relations of diarrhœa to phthisis are, therefore, as I have said, not simple and invariable, and you will be prepared to find that the success of treatment is not uniform.

I need say nothing about the severity of the diarrhœa; this will depend upon the amount of local lesion. It may be only one soft, murky stool per day, or in severe cases the stools may be frequent and watery. The character of the stools will depend upon the condition of digestion, and the kind of food taken, and whether or not there is ulceration of the bowel. I would say that the fact that a patient has a single murky stool daily is a most serious complication in his case. He may never think of alluding to it, or may, indeed, think that it is rather a favorable occurrence; but in reality there is no more subtle and certainly destructive process than the slightest looseness of the bowels, if continued, particularly when it occurs in a weak state of the system. It is not merely the loss of the serum of the blood, amounting perhaps to two or three ounces in twenty-four hours, but it is also the fact that the peristaltic action of the bowels is, in such cases, too rapid—the ingesta are not thoroughly digested, and the nutritious elements are not absorbed—that makes this a dangerous complication, and deserving of the most careful treatment; for the nutrition suffers, both by what it fails to absorb and by what is excreted. As the stools increase in frequency to two or three or more a day, the complication becomes more serious. I never wait for the patient to tell me, of his own accord, that his bowels are loose, but tell him to report to me the first loose stool he has.

Now, as to the treatment. Rest in bed, I should say, was essential in such cases, for I assure you, if the patient is allowed to go about and the diarrhœa to continue, you will find great difficulty in stopping it. Rest in bed, then, with absolute liquid diet of the most nutritious character, consisting of milk, arrow-root, meat broths, finely minced meat, and other articles of this kind, must be continued until the tendency has been entirely overcome and the stools have been normal for a day or two. A moderate amount of opium must be used, to control the tendency to diarrhœa. As to astringents, nitrate of silver, given in minute doses, guarded by opium, is, I think, a most valuable remedy. Bismuth does well in most cases. Sugar of lead or tannic acid with opium is also very good. Aromatic sulphuric acid with sulphate of morphia, and camphor solution will do very well in many cases. The nitrate of silver may be given in pill form, or in small doses dissolved in the syrup of acacia.

If you find that there is a widespread catarrh, with involvement of the duodenum, and extension of irritation into the bile ducts with obstruction to the flow of bile, I would advise you to preface the treatment by small doses of calomel, soda and opium, given for a few days until the tongue begins to clean and the character of the stools shows that the bile passes freely. Then you may substitute nitrate of silver and opium, or one of the other astringents. Such patients are very susceptible to the action of mercury, and we must use the calomel in small doses. It may be given according to the following formula:—

℞. Hydrarg. chloridi mite, gr.ij
Sodii bicarb., ʒj
Pulv. opii, gr.iij. M.
Ft. pulv. No. xij.
Sig.—One every four hours.

These are to be taken until they produce the desired effect, or are all taken.

In reading medical books and papers, you will frequently see specifics for tuberculous diarrhœa—the last one I saw was coto bark—but you will find them all fallacious. Many of them are, no doubt, good astringents, but their effect is no better than that of any other astringent given in a proper dose; and to recommend any drug as a specific for the condition I have described is

utterly absurd. This complication, then, of diarrhœa, is an exceedingly important one; it wastes the patient's strength and flesh, it renders him still more susceptible to damp and cold and predisposed to extension of his lung trouble, and consequently it may be ranked among the most serious complications and deserving of the most careful treatment.

The last of these great complications is the laryngeal complication, or as it is called tuberculous laryngitis; but just as we have seen in the case of phthisical diarrhœa, many of these cases are not tuberculous at all. Laryngitis occurring in the course of phthisis may be an expression of tuberculosis, and we may find miliary tubercles in the follicles of the mucous membrane, but patients with phthisis are very liable to get attacks of ordinary catarrhal laryngitis, and such attacks are, for precisely the same reason as in the case of the diarrhœa, apt to become troublesome and leave behind lasting lesions, thickening of the membrane and enlargement of the follicles, with hypersecretion. These cases of chronic laryngitis may be developed without there being any tubercle in the case, or it may be due to tubercles forming at the beginning of the attack or developed later, after the irritation has lasted for some time. Here we have an explanation of the fact that in many cases we are able to effect a cure, while in others we utterly fail. After true miliary tubercles have formed in the larynx, I fancy that an arrest of the disease is of the rarest occurrence, for the state of the system and the presence of these tubercles and ulcers favor increased congestion, and the course of the disease is steadily downward. In cases where the lesion is of a catarrhal character, you may, by judicious treatment, greatly relieve if not cure the catarrhal trouble.

Sometimes the patient has his laryngeal trouble before the phthisis; he is disposed to have catarrhal attacks affecting the larynx, which run into a chronic form; ulceration occurs. He then gets a catarrhal pneumonia, which runs into phthisis. But more frequently he has had phthisis for some time, he gets a little hoarseness, which becomes more marked, articulation is painful; later, pain on swallowing is complained of, and finally the patient becomes almost aphonic, speaking with the greatest difficulty. He has frightful attacks of laryngeal cough, very painful, and spasmodic; these attacks are often brought on by talking or attempting to swallow. Deglutition becomes very painful, and particles of food get into the larynx and bring on these attacks of coughing. In some cases the patient becomes completely aphonic, and unable to swallow, so that this may become one of the worst complications of phthisis. There is no other that causes so much suffering, and hurries the patient downward so rapidly, as this.

Fortunately, by means of the laryngoscope, we are able to demonstrate the character and seat of the lesion. On examination, you will find the mucous membrane of the aryteno-epiglottidean folds red and swollen, the arytenoid cartilages forming large masses, and the mucous membrane covering them may be ulcerated. Sometimes ulcers are found on the true and false vocal cords, and by care, we can sometimes see the follicular structure of the posterior part of the trachea hypertrophied and ulcerated. Hemorrhage may at times occur, and there is often a copious purulent secretion.

We should always warn the patient against the slightest exposure, and when the least hoarseness occurs, we should treat it immediately, for by so doing we can often prevent the development of the later stages. In the early stages counter-irritation, by means of a blister, or by the repeated application of iodine, or of iodine and croton oil, and the direct application of astringents, as sulphate of zinc, grs. x–xl to the ounce, will often cut short the attack. If the attack is more marked, and we have not been able to cut it short, the larynx must be put to rest as much as possible, by inducing the patient to do without speaking, not even whispering, and to communicate everything by writing. My attention was called to the great importance of absolute rest in this form of laryngitis, by seeing the marvelous results that followed the operation of tracheotomy in cases of syphilitic laryngitis. The food should be unirritating, and great care should be taken that no particles get into the larynx. The patient should be careful that he does not take a fresh attack from chilling of the surface. Opium must be given, to allay irritability and cough. Counter-irritation must be steadily kept up. Topical applications must be used, to relieve the swelling and favor cicatrization of the ulcers.

Now as to topical applications. I think that in treating these cases the strength of the solutions used is often too great. We must remember that we have to deal with a not very highly vitalized tissue, and one which, when in a state of chronic inflammation, will not respond to strong applications. You will find that mild applications will do more good than strong ones. Solution of sulphate of zinc, or of the salts of iron, or of iodine,

will be found of service. Lately I have been using a solution of iodoform in ether or chloroform, varying in strength from grs. xv to the ounce up to a saturated solution, which is, I think, about ʒj to the ounce. This is a very unirritating application, and it certainly possesses very marked absorbifacient and alterative powers. Of course, each of these applications is to be made only to the diseased spots by the aid of the laryngoscope.

Inhalations are very valuable in the treatment of the laryngeal complication of phthisis. They may be used with the ordinary atomizer, which is a good method, but apt to excite coughing. In this way we may use nitrate of silver, tannic acid, sulphate of copper, sulphate of zinc, iodine, etc. We may use an inhaler made of a piece of rubber tubing, in which is placed a number of small rolls of bibulous paper. The solution to be inhaled is dropped in at one end, and then the patient uses it as an ordinary cigar. I have made a little alteration in this, by substituting for the rubber tube a glass tube with a constriction near one end, and for the paper, pumice stone, which makes it more cleanly. With this we may use a number of volatile solutions. In other cases we may employ a sort of mask made of two pieces of rubber, with sponge between them. By this means the patient may breathe medicated vapors for hours at a time. We may use with this tar, carbolic acid, iodine, etc.

We have now finished the discussion of the great complications of phthisis, and next week I shall ask your attention to the treatment of the pulmonary condition itself.

Communications.

A CASE OF OBSCURE DISEASE OF THE RECTUM.

BY REUBEN A. VANCE, M.D.,
Of Cincinnati, Ohio.

The following case, in which the phenomena of anal fissure were simulated by an ulcerated sacculus without the slightest external evidence of the existence of such a lesion, is offered as an illustration of certain of the more obscure forms of rectum disease :—

Early in February, 1880, I was consulted by a medical acquaintance of this city in reference to the case of his sister, who was then suffering from an obscure ailment of either the anus or the lower part of the rectum. The following are the more noteworthy points in the history of the case. In September, 1878, the young lady, then in her eighteenth year, paid a visit to some friends in Indiana, where she contracted intermittent fever. Although the chills were speedily controlled, still she did not regain her accustomed health. During October she began to suffer from a distressing itching of the anus, which was at first intermittent but finally became constant. She suffered so much from this itching of the fundament—the distress was so acute, and the tendency to relieve the intolerable irritation by scratching so great—that she was debarred all the festivities of the season, and compelled to forego many long anticipated pleasures. Between Christmas and New Year, 1878, she called attention to a marked enlargement of her right hypochondriac region. She remained constantly in her room, and could not be induced to take any out-door exercise. Alarmed at the impairment of her health, her brother advised a local examination, and urged her to express a preference for some surgeon, and commit herself to his care. She protested so strongly against the examination that all sorts of measures were resorted to for her relief, rather than again broach the topic she seemed to dread so much. In April, 1879, she complained of pain; she said that occasionally, instead of the itching, which, to a greater or less degree, was present all the time, she would have pain deep in the rectum. At first, the pain came on only after movement of the bowels; ultimately pain was added to the itching, and one or other was always present. The patient lost flesh and strength rapidly; she was sent East for change of air and scene. While in New York, in compliance with the earnest wish of her family, she consulted a well known surgeon. The rectum was thoroughly explored, the patient herself urging a careful search for the cause of her suffering. Finding nothing in the rectum or about the anus to account for the symptoms, this surgeon requested permission to make a vaginal inspection. To this the patient objected so strongly that no further exploration was then made. A few weeks subsequently her distress became unbearable, and she requested that another surgeon might be summoned and the lower bowel again examined. To this surgeon she wrote a note portraying her symptoms, in which she said that she was suffering from but two things; the first, a constant itching in and about the anus, and the second, a pain, not constantly but only occasionally present—an agonizing feeling of burning and stabbing following every movement of the bowels.

It was understood when the examination commenced, that the inspection was to be limited to the rectum and anus. The surgeon gave a

written report of his investigation, and said that both rectum and anus presented a perfectly healthy appearance; that in his judgment the pain and pruritus originated from "some reflex irritation" from the organs of generation. A course of medication was advised, and the patient remained East until late in the autumn of 1879. There was marked amendment during the last few months she was in New York, but as soon as she came home she began to suffer as before. Her general health now gave way, and when I saw her in February, 1880, she looked like one in the last stage of pulmonary consumption.

When first consulted I was told the great repugnance the young lady had to a vaginal examination, but that she had finally consented to submit to any measure her advisers thought necessary. February 9th, I called at her residence for the purpose of making an examination. The integumentary folds radiating from the anal aperture were congested, thickened and œdematous, doubtless as the consequence of constant scratching, but there was no trace of anything like an anal fissure at any point within the anal canal. The lining membrane of the rectum was searched with the utmost care, but no lesion of any sort was revealed. In short, no evidence of anything more than the irritation caused by the scratching could be found at any point. It is true that there was more or less hypertrophy of the anal sphincters, but that could arise as well from a reflected irritation as a direct lesion of the part. A second painstaking review of every tissue and part of the rectum and anus convinced me of the facts just detailed, and I was upon the point of abandoning all hopes of finding a local lesion, when, as a matter of form—for there were no evidences of disease about them—I determined to pass a probe into each one of the little sacculi of the anus. My probe could not be forced into the first one; with the second one I fared no better; but with the third one, after an ineffectual attempt, the probe passed into the sacculus. No sooner did the probe effect an entrance, however, than the patient screamed with pain, there was a spasmodic retraction of the levator ani and sphincter muscles, and the part I was examining was forcibly withdrawn from view. The spasm of the pelvic and anal muscles was so great, and the patient's suffering so intense, that I was compelled to postpone further investigation for a short time. Later in the day I found the anal sphincters so irritable, that I deemed it advisable to postpone the inspection for forty-eight hours. During the ensuing two days the patient was confined to her room. February 11th, the examination was renewed. Finding the sphincters so firmly contracted that a view of the diseased sacculus was impossible, I proposed the use of an anæsthetic and mechanical distention of these muscles. The patient promptly consented to the latter, but refused the anæsthetic. She was placed on the left side, with her thighs flexed upon the body, her knees being brought as closely as possible to her chest, and her hips resting on the edge of the bed; in this position it was no severe task for the operator to insert first one forefinger and then the other within the anal canal, and slowly distend the contracted sphincters. So soon as partial atony was produced, the forefingers were withdrawn and the thumbs inserted; the anal canal was then distended to the utmost, pressure being made successively in different directions until every part of the rectum outlet had been thoroughly stretched. It is worthy of note that no great amount of pain is produced when this part is slowly distended, even if the force applied be great enough to produce complete atony. When the thumbs were withdrawn the mucous lining of the rectum protruded to such an extent that the whole of the columns of Morgagni were exposed. A careful search was then made for diseased sacculi; but one, however, appeared enlarged. The probe, properly curved, was used between the various columns; in but the one instance could a canal leading to a diseased sacculus be found. In this one—the sacculus into which the probe had been forced the day the examination was begun—the site of the sacculus felt as if a buckshot were embedded in the tissues, so hard and swollen was the part. A small probe-pointed tenotome was carefully forced along the canal, and as soon as the sensitive point was touched the handle was brought down and the edge of the knife made to sever the inner wall of the sacculus and expose the diseased point. This done, the cause of the young lady's suffering was revealed. Here, on the left side of the anus, and at a point where there had been no unusual sensibility, an indurated ulcer had formed within one of the little sacculi between the columns of Morgagni. When the sacculus was opened and the ulcer exposed it seemed very much like an ordinary fissure of the anus, but before cutting open the sacculus there was no evidence whatever, save the symptoms the patient complained of, to indicate the existence of such a lesion. A drop of fuming nitric acid was applied to the

very centre of the exposed ulcer; almost immediately the part was flooded with a solution of carbonate of potash. The acid was so quickly followed by the alkali that the patient suffered no pain from the procedure. Upon taking leave of the patient I assured her she would have no further need for my services—that she would at once get well.

February 14th, I was informed she was suffering from severe pain in the abdomen; on the 15th I was hastily recalled. She told me that ever since the operation she had suffered colicky pains and had a bilious discharge, almost all fluid, but that all morning something like the old pain had returned. A digital exploration revealed a mass of hardened fecal matter, too large to pass through the anus, distending the lower part of the rectum. This finally yielded sufficiently to the attacks made on it to pass through the anal ring; an immense quantity of very offensive fluid fæces followed; and the patient fell asleep as soon as she could be returned to her bed. The next day her exhaustion was really alarming, but ultimately she rallied, her strength gradually returned, and at present she is in perfect health.

In this case there are several interesting points: The pathognomonic symptoms of anal fissure present themselves in an individual pronounced to be free from any lesion of the terminal portion of the large intestine, or anal orifice. Again: fecal impaction seems to have developed under the very eyes of the patient's surgical advisers, not one of whom—myself among the number—gave that contingency a moment's consideration. It was simply owing to the fact that the last surgeon gave attention to the always obscure and generally insignificant anal sacculi, "as a matter of form," that he stumbled upon the lesion causing the patient's sufferings, and was enabled to effect a cure. Had he not, in a mere spirit of routine, determined to probe the sacculi intervening between adjacent columns of Morgagni, he would have given the patient no more assistance than his predecessors. Like the latter, and more culpably than they, he paid no attention to the young lady's complaints of an enlargement in one side; the only excuse he has to offer is that at first his examination was interrupted just as he arrived at the critical point of the case, and the next time he worked so long in stretching the sphincters and in atonying the muscular tissue at the lower end of the rectum, and was so tired by the time he had cauterized the exposed fissure, that he temporarily forgot to inquire about the matter. When next he saw the patient the fecal mass had been removed to the rectum, and was in a position to be destroyed by mechanical means.

The whole history is an interesting commentary on, and illustration of, obscure affection of the rectum and anus. Symptoms of rectum disease succeed intermittent fever, and last for seventeen months during which the unfortunate patient suffers untold agony, and fruitlessly seeks relief far and near. While all the phenomena developed point unmistakably toward fissure of the anus, or irritable ulcer of the rectum, yet it is impossible for the surgeons in whose care she is placed to find any such lesion. Ultimately a probe is by chance brought in contact with an ulcer, which has developed deep in one of the little sacculi between the columns of Morgagni; as a consequence the surrounding tissues become swollen and thickened, and the ultimate discovery of the lesion causing the patient's agony is assured. It seems that the straight fibres of the external, or longitudinal layer of the muscular substance of the rectum curves around the thickened lower border of the internal or circular layer, and is gathered together into columns before proceeding upward to be attached to the fibrous substratum of the loose cellular tissue beneath the mucous membrane of the lower fourth of the rectum. In this way are formed the pillar-like projections at the end of the rectum, over which the mucous lining is reflected, constituting the columns of Morgagni. In number, they vary from nine to thirteen—occasionally, but from four to seven are present. If the mucous folds between adjacent columns be investigated they will be found to end inferiorly in lacunæ which are located immediately below the lower margin of the internal sphincter. At this point membranous folds of a semilunar form can be seen, the number of which will correspond with that of the grooves themselves, which convert the depressions between the columns of Morgagni into lacunæ that are from two to ten lines in depth. The mouths of these little pit-like cavities are on the same level, and in health their orifices can be easily traced around the anus. These little sacculi, which naturally contain a mucus that is discharged when the anus is distended, may become diseased in different ways. That as painful an affection as fissure of the anus may result from an ulceration within a sacculus which presents no evidence of its situation until a probe is inserted, the foregoing case amply illustrates.

I need not dwell upon the importance of a careful study of the state of these little sac-

culi, in cases in which the rectum is the site of painful symptoms without there being any apparent morbid anatomical changes sufficient to account for them; nor insist upon the fact that the surgeon is never prepared to pronounce upon the condition of the terminal portion of the large intestine until these little sacculi have been examined.

PARTIAL FRACTURE OF BOTH BONES OF THE FOREARM NEAR THE WRIST JOINT, AND SEPARATION OF THE DISTAL EPIPHYSIS OF THE HUMERUS, FROM A FALL ON THE PALM OF THE HAND.

BY J. S. WIGHT, M.D.,

Professor of Surgery at the Long Island College Hospital.

Reported for the MEDICAL AND SURGICAL REPORTER.

On the 23d of June, 1880, Joseph Hartwell, eight years of age, fell from a cart and struck on the palm of his right hand. That the palm of his right hand came against the pavement could not be doubted, because it was contused near the base of the radius, having the dirt of the street driven into the integument. The patient was suffering great pain, and was holding his right forearm in his left hand, as his older brother came with him into my office. An examination showed the following points, namely: 1. Both bones of the forearm were broken near the wrist joint, the hand being carried backward. 2. The lower end of the humerus was completely broken off, the forearm with the fragment being carried backward and outward.

The following observations were made in regard to the first point:—

1. The fragments of both radius and ulna were about five eighths of an inch in length.

2. These fragments met the upper fragments at an angle of about forty-five degrees, having been bent backward from their normal line with the long axis of the bones of the forearm.

3. They did not deviate either outward or inward.

4. The carpus could be felt under the flexor and extensor tendons and in the concave floor of the base of the radius, very readily.

5. The patient could not move the hand on the injured side. The surgeon could move the hand on the injured side in every normal way, but to a limited extent.

6. There was no rotary displacement of the distal fragments and the hand. In fractures of the base of the radius the hand and distal radial fragment are rotated outward.

7. The fractures in both bones were "green sticks," and the distal fragments were firmly fixed in their new position.

8. Reduction was made by taking hold of the lower end of the upper fragments with my left hand and resting that hand on my knee, and by taking hold of the lower fragments and the hand with my right hand, *and then bending the fragments back into place, as nearly as possible. This required very great force.*

9. The reduction was not quite perfect. The lower fragments bent very slightly backward, and tended somewhat outward. This outward tendency was partly overcome by the splints that were applied.

10. *From the beginning to the end of the examination and the reduction there was not the least sign of crepitus.*

The following observations were then made in regard to the second point:—

1. The fracture of the humerus appeared to be a *diastasis.* The lower fragment was short, and was carried backward and outward with the bones of the forearm; and the distal end of the upper fragment had a rough and irregular outline that could be felt in front, as it projected under the skin and subtegumentary tissues.

2. The displacement of the epiphysis of the humerus, and the forearm backward was about one inch, outward about three-fourths of an inch.

3. The forearm was about semi-flexed on the arm, and was in a state of mid-rotation. The forearm could not be moved by volition. There was mobility of the forearm and the humeral fragment in the hands of the surgeon.

4. There was a hematocele in the flexure of the limb over the elbow joint, from a rupture of one of the cutaneous veins.

5. The reduction of the fragments of the humerus was made by the ordinary manipulations for reducing a dislocation of the forearm. The lower fragment went into place without much difficulty, and was readily kept in place.

6. During this reduction there was no bony crepitus. There was a rough "rubbing feel.

After the reductions of the displacements of the forearm and the arm were made, two double-angled splints cut from wire-cloth were applied, one on the outside and one on the inside of the injured upper limb. Thereupon the little patient experienced a sense of relief and comfort.

In regard to this case the following remarks may now be made, namely:—

1. Under the circumstances of the injury, in a

patient eight years of age, we might have expected (1) a fracture of the base of the radius; or (2) a dislocation of the forearm; or (3) a fracture of one of the condyles of the humerus; or (4) a supra-condyloid fracture of the humerus; or (5) a fracture of the base of the radius complicated by a dislocation of the carpus backward.

2. The injury was caused by a fall on the palm of the hand. The energy of the falling body met with the resistance of the pavement. The fractures were caused by the bones being caught between two counter forces.

3. It does not seem probable that either fracture was produced before the other; as the bones were firm bodies, the reaction would be transmitted to the elbow quite as soon as to the wrist; and the interval of time in this respect would be so small, that we can say that both fractures were produced at the same instant.

4. The inference would be that the bones of the forearm were stronger than the humerus, because the humerus gave way entirely, while the bones of the forearm were only partially broken.

5. The radius appeared to have suffered most, because after the reduction of the bent bones of the forearm, the fracture of the radius was more nearly complete than the fracture of the ulna.

6. In all my experience I have never before seen a case like this—so much injury and of so exceptional a kind, caused by a fall of so little severity.

Passive motion was made on the third day, and continued at frequent intervals for some weeks. The function of the hand was well restored; the rotation of the forearm was not quite so good as normal; while the function of the elbow joint was somewhat impaired. A good deal of bony enlargement united the fragments of the humerus. The case made a better recovery than I have sometimes seen, when only one condyle of the humerus has been broken off. The good result was in part due to early passive motion.

American Dental Association.

At the session of the American Dental Association, held in Boston, the report on Section 2, on dental education, urged that the Association should fix a standard of preliminary education to be required by dental colleges. The question whether dentistry was a specialty of medical science or not was considered. Dr. Brophy urged the necessity of dentists having a thorough medical education and a complete knowledge of dental surgery. The Association voted to hold its next annual meeting in New York City.

Hospital Reports.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

CLINIC OF JOHN ASHHURST, JR., M.D.,

Professor of Clinical Surgery in the University of Pennsylvania.

REPORTED BY CHAS. W. DULLES, M.D.,

Surgical Registrar to the University Hospital.

Tracheal Fistula, with Stenosis, the Result of a Suicidal Wound—Operation—Recovery.

GENTLEMEN:—The patient whom I show you to-day has an injury of a very unusual and interesting character. Some months ago—the physician who sent him here does not state in his note how many—he made an attempt at suicide, by cutting his throat. This attempt, however, failed, and he recovered from the immediate effects of his wound. But, unfortunately, this, which communicated with the trachea, never entirely healed, and in the process of repair has undergone such cicatricial contraction as has brought about a marked narrowing of the calibre of the windpipe. This has gone so far as to make the man's respiration very labored, and, indeed, to indirectly imperil his life. The man cannot speak at all, and you observe how hurried is his respiration.

This is, therefore, a very urgent case, and we must see what we can do for our patient's relief. Cases of the kind are very rare, and, until the trachea is opened and a tube inserted, so as to relieve the dyspnœa and an exploration made of the parts above the suicidal wound, we cannot say certainly what can be done. The patient is anxious that our operation shall go further than simple tracheotomy, so that the occluded tube may be restored to its functional activity.

Mr. Henry Lee, of St. George's Hospital, London, had a case where he succeeded in accomplishing this: he first did a tracheotomy, and afterward, by successive dissections upward, removed parts of the cartilages which seemed to have overlapped and united thus faultily; he then used a tracheal tube, somewhat T-shaped, so that the air could pass either through the throat or the neck, as should be determined, by setting a valve in the tube. Dr. Cohen, of this city, has designed a somewhat similar tube, with a ball valve, which regulates the respirations very efficiently.

In operating upon our patient I will do tracheotomy first, so that I may avoid having blood flow back into the trachea when I come to the operation above. I shall also use as large a tracheal tube as possible, so that it may help, by pressure, to control any hemorrhage which may come from the sides of the wound and block off any blood which may find its way down from above.

You see that we cannot etherize this patient in the customary way. The towel will have to be held over the contracted opening, through which the air goes whistling in and out, and if, during the operation, we find the ether acting badly, or the towel in the way, we shall just have

to desist from the anæsthesia till we can regulate it properly.

You will observe how carefully I dissect through the tissues which overlie the trachea. I do not prolong the suicidal wound downward, but keep entirely below it, for I do not wish to have any communication with the trachea till I have controlled whatever hemorrhage may occur. It would not do to have blood trickling in here while I do the necessary dissecting. When I come upon the white rings of the trachea I hook it up with a tenaculum, and entering a small scalpel below, cut upward through several rings. In this part of tracheotomy you must always turn the edge of your knife upward, so as to avoid running the risk of cutting the important structures which lie close to the supra-sternal fossa. For it has even happened that the innominate artery or vein has been accidentally opened; of course, with a fatal result.

In inserting the tracheal tube the trachea is steadied with a blunt hook. Immediately there is a rush of air through this new passage, driving before it some little blood and mucus. You will observe, too, the effect of a freer canal; the respirations diminish in frequency, and lose the anxious character they had before the operation, and before the patient was anæsthetized.

You will also observe how the presence of the tube in the trachea excites efforts at coughing, which are of a peculiarly asthmatic character, and dependent upon the spasmodic reflex contraction of the respiratory muscles. These efforts become less marked as the anæsthetic is renewed and lulls the local and general sensibility.

I have now explored the tube above the self-inflicted wound, and find I can pass a flexible catheter up through the larynx. As I do this, see how the foreign body in this apparatus excites coughing.

I find here that the lumen of the trachea, just at the level of the cricoid and lower part of the thyroid cartilages, is almost entirely occluded. I shall now dissect back the dense cicatricial tissue which is making tension upon the tube, and then with strong scissors remove enough of the displaced cartilages to make a better and fuller opening through them.

(*Note.*—From this point the operator proceeded until he had cleared a passage through the larynx and could pass a tube up into the mouth. This was subsequently kept open by using the solid stem of a tracheotomy tube as a bougie.

The patient gradually recovered the use of his voice, and was dismissed from the hospital three months later with free respiration through the tracheotomy tube, and the ability to talk quite audibly, though in a hoarse and whispering voice.—Rep.)

Editorial Department.

Periscope.

Case of Labor with Albuminuria.

Dr. Stanley Haynes, of Malvern, reports the following case in the *Lancet*, July 10th, 1880:—

On July 24th, 1878, at 10.30 P.M., without having any previous knowledge of the patient, I was called to attend Mrs. P., a gardener's wife, a primipara, aged twenty-six. A nurse had arrived just before I was sent for (about half an hour previous to my attendance), and been so alarmed by the condition of the patient that she had immediately given a glass of hot brandy and water, and said that a doctor must be obtained directly. On my arrival the patient looked as if she had had serious hemorrhage, but there had not been any. The face had a deadly pallor, the nostrils were contracted, the eyelids half closed and twitching, the breath was cold and breathing slow and superficial, and there was a cold perspiration on the forehead; the pulse was barely perceptible, and slow. The patient was calm and sensible, said she felt very well, and was quite unaware of there being anything unusual. She calculated she had gone between seven and eight months. There had not been any convulsions. Labor had begun about 4 P.M., with ordinary prodromata, and pains had not become regular or frequent until about 7 or 8 o'clock, when the liquor amnii, in apparently small quantity, escaped, and the patient had continued about her household vocations until then. There was no vomiting. The patient had not complained of illness or debility. (Neighbors subsequently stated she had been very pale during her pregnancy.)

On examination there was not, and had not been, any hemorrhage; the external genitals, the thighs, legs, feet, and arms felt cold, like those of a corpse, and the ankles were œdematous. The abdomen could not be termed warm. The warmest part of the body was the thorax, and that was of low temperature. I had not taken a thermometer. The os uteri was of the size of a shilling, dilatable; the presentation was left occipital anterior, and the pains came on about every ten minutes, were slight, and appeared to be almost unknown to the patient. Brandy and water was repeated in frequent small doses, with one-drop doses of laudanum, and heat applied to the feet, calves, thighs and abdomen, producing warmth where applied, but very little improvement to the circulation or respiration. The pains gradually became more frequent and the os slowly enlarged. At about 2 A.M., as the general state of the patient continued as described, I sent for my friend, Dr. Thelwall Pike, in consultation. On his arrival, about three o'clock, he approved of the treatment so far, agreed it would be better to watch and wait carefully unless there should seem reasons for expediting the labor, and regarded the case with anxiety. Soon after he left the

pains became stronger, the labor advanced rapidly, the patient remaining cheerful and suffering very little even during strong expulsive efforts, and a recently dead female child was born. After a short interval pains recurred, and the placenta came away with very little, and that pale, hemorrhage. The p tient expressed herself as very comfortable and soon became warmer, and I left her doing well at about 8 A.M. She made a good and rapid recovery, and seemed surprised I had been anxious about her.

When the lochia had ceased the urine became almost solid on boiling; it did not contain any casts or crystals. There was marked leucocythæmia. Under chalybeates and potassic chlorate she speedily improved, and assumed a natural appearance, and the albuminuria steadily diminished and ceased. On September 3d (six weeks after parturition) she was so far recovered she did not wish for further attendance. I advised recourse to the treatment in the event of relapse or of pregnancy.

On March 31st, 1879, eight months after confinement, I was asked to see her again, and found leucocythæmia and albuminuria, and prescribed iron and potash as before. She took this for a month only and recovered. In August she had a living child at full time, after a natural labor, and without the attendance of a medical man. Since then she has continued well.

Diseases of the Eye Occurring in Connection with Pregnancy.

Mr. Henry Power contributes an important series of articles on diseases of the eye in connection with pregnancy, to the *Lancet*, May 8th, 15th, 29th, 1880. He commences by reviewing the physiological changes induced by pregnancy, and concludes that the quantity of blood, though increased absolutely, is not relatively, and that in pregnancy a condition of general anæmia is far more commonly met with than one of hyperæmia. From an examination of the various cases which have fallen under his notice, he would classify the diseases of the eye in connection with pregnancy under three heads, namely: 1. Affections depending on general anæmia and exhaustion; 2. Those consequent on some special lesion of the nervous system; 3. Those depending upon, or rather associated with, albuminuria. Among diseases attributable to exhaustion, the most common are ulcers of the cornea, which may be either spontaneous or arise from some slight injury. They are often central, are slow in their progress, and are not usually dangerous. The treatment may be summed up in two words, rest and tonics. The former indication may be fulfilled by a two or four-grain solution of atropine or eserine, and the application of a pad of cotton-wool and a bandage; the latter by quinine. During lactation, a more dangerous form of ulcer is often met with, causing destruction of the cornea, with eventually atrophy of the globe. Paracentesis corneæ is often required in such cases. Another sign of exhaustion in pregnancy is impairment of the power of accommodation, due to enfeebled action of the ciliary muscle. Glasses, in suitable cases, will necessarily be required, but much good also may be effected by tonics, especially strychnia in small doses. As regards special lesions, the author has witnessed what he considers an increased tendency to lachrymal abscess, and to the development of cataract. Lesions of the nervous system, or lesions implicating the nervous apparatus of the eye generally, he divides into two groups, the intra- and the extra-ocular. The former affect the retina, the latter the optic nerves, chiasma, optic tract, and central ganglia. The retinal affections are almost limited to cases of albuminuria, though, also, cases of hemorrhagic glaucoma, and miliary hemorrhages unconnected with albuminuria in pregnancy have been noted by Galezowski. Two cases are recorded by the author, in which retinal hemorrhages during pregnancy passed off harmlessly, and one in which they were of fatal significance. As regards the treatment of such cases, it is the same as that of retinal disease generally, no special treatment being demanded for the eyes. Some writers have recommended the induction of premature labor in these cases, but the author considers more data are required before a positive opinion can be pronounced, more especially as to the period when labor could best be induced. As regards intracranial diseases in pregnancy, the author suggests they could almost be classed under the head of 'anomalous affections.' He gives the histories of cases of partial or complete loss of vision from post-partum hemorrhage, and explains such either by abolition of the circulation in some portion of the cerebrum, or by some lesion of the delicate tissue of the central nervous system from sudden diminution of pressure. Many such cases eventually resolve themselves into atrophy of the optic disc. A comparison between this condition and the occurrence of chorea in pregnancy may perhaps be instituted.

Influence of Tobacco Smoking Upon Health.

In the *Revue d' Hygiène* for November 15th, 1879, Dr. Decaisne observes that the excessive use of tobacco causes in some subjects intermission of the beats of the heart and radial artery. Out of eighty-eight smokers who came under his observation during a period of three years, he found twenty-one cases of intermittent pulse, without any organic lesion of the heart. He states—

1st. That none of the subjects who came under his observation had organic disease of the heart.

2d. That none of them were in a state of health favorable to the development of intermittence in the beats of the heart.

3d. That in nine cases the complete abstention from smoking tobacco was sufficient to restore the cardiac rhythm and the system to their normal condition.

He therefore says that the abuse of tobacco produces in some subjects a condition which he terms *nicotism* of the heart, which is manifested by intermissions in the beats of that organ, and in the pulsation of the radial artery. It is sufficient in some cases to suppress or diminish the use of tobacco in order to stop or diminish the irregularity in the heart's action.

Dr. Delaunay, in commenting upon Dr. Descaisne's paper in the *Revue d' Hygiène* for Janu-

ary 15th, 1880, calls attention to the influence of the emanations from tobacco upon pregnancy. In a poor district of Paris there is a manufactory of tobacco in which 2000 women are employed. According to the evidence of a midwife who has attended a great number of women employed in this factory during their confinements, they are peculiarly liable to miscarriages, which they attribute to the influence of the exhalations from the tobacco. Some of the women, who are not altogether dependent upon their earnings from the factory, leave it when they become pregnant until after their confinement. One woman who had twice miscarried while working at the factory, left it when she was in the fifth month of her third pregnancy. Her child was born alive at the proper time, but died soon after its birth. The mother did not return to the tobacco factory, and her fourth pregnancy terminated in the birth of a healthy child, who survived. During her first three pregnancies she suffered much from obstinate vomiting—due, perhaps, to the action of the tobacco.

From these and similar data Dr. Delaunay deduces the following conclusions:—

1st. Tobacco has a pernicious influence upon the health of children and mothers.

2d. It impairs the health of pregnant women, and causes miscarriage.

3d. It has the same noxious effect upon children weak from their birth.

4th. It diminishes the quantity of milk and alters its quality for the worse, and, consequently, prevents the proper growth of the child, who, indeed, often dies, a victim to his mother's occupation.

Acute Eczema of the Face, Following Neuralgia.

Dr. John Cavafy, F.R.C.P., assistant Physician to St. George's Hospital, reports the following case in the *British Medical Journal*, July 24th, 1880:—

Charles F., aged 38, pastry-cook, applied as an out-patient on February 13th, 1880, stating that for five days he had suffered from severe pain in the left side of the head and face. The pain extended over the orbit, cheek, and lower jaw, and also to some extent over and behind the ear. On the scalp and down the neck numerous tender spots were found, the most marked being over the eyebrow and just behind the ear. He declares that the pain was at times maddening, but regularly intermitted about 6 o'clock in the evening, to begin again on the following morning after he had risen. The left conjunctiva was slightly injected, and there was some lachrymation of the left eye, but the skin itself was not reddened or swollen, and appeared normal in every respect. There were no carious teeth, nor was the pain more severe along the course of the dental nerves.

As the neuralgia intermitted so distinctly, he was given quinine, of which he took nine grains daily for four days, without the least benefit. The pain continued as before, and was worse than ever on February 17th, on the evening of which day it subsided as usual. On the following morning the whole left side of the face was found to be much swollen, and from that time there was no return of the neuralgia. The swelling of the face, however, continued to increase, and on February 20th, when he was seen again, there was acute eczema affecting the parts which had previously been the seat of pain. The whole left side of the face was red and extremely œdematous, the eyelids especially being enormously swollen, so as to quite close the eye, the left ear was red and swollen, as was also the neck in its neighborhood, and the whole affected parts were streaming with a transparent discharge from innumerable small vesicles. At the margin of the scalp and beard there were a few yellowish gummy crusts. The swollen skin was not sharply circumscribed, but gradually shaded off into healthy texture, the demarcation being obscurely marked by numerous bright-red papules. There was no pain beyond a sensation of burning and smarting, and the eczema yielded to purely local treatment, no neuralgia taking place after its subsidence.

Although a variety of erythematous and vesicular skin eruptions have been noticed to occur occasionally after neuralgia (more especially herpes zoster), yet an acute dripping eczema is a sufficiently rare sequel to merit a short record. The case, moreover, is not without interest from the point of view of diagnosis, as the swollen face and closed œdematous eyelids had a strong superficial resemblance to erysipelas. On looking a little more closely, however, the various points of difference became evident; these being a less angry redness, the absence of a sharp line of demarcation, and the presence of numerous bright red points (papules) beyond the swollen skin. The most valuable diagnostic points, however, were to be found in the general condition of the patient; there had been no antecedent rigors or vomiting, there was no general malaise, and above all, no fever, the temperature being barely above the normal; whereas, in erysipelas, it would have been three or four degrees higher, at least.

Stigmata of Maize in Urinary Complaints.

Dr. Dupont of Buenos Ayres, communicates to the *Revista Medico Quirurgica* some interesting facts in relation to the therapeutic value of the above vegetable product, from which we transfer his ultimate conclusions, which are the following:—

1st. The stigmata of maize have a most evident action, I do not say always favorable, nor in all the affections of the bladder, whether recent or chronic.

2d. In acute cystitis from traumatism, as well as in blenorrhagic cystitis, they produce a very pronounced diuretic effect, with exacerbation of the pains. It is, therefore, preferable in these cases to abstain from their employment.

3d. It is in *gravel*, uric or phosphatic, and in chronic cystitis consecutive to gravel, and in mucous or muco-purulent catarrh, that the best results are obtained. All the disagreeable symptoms disappear rapidly—the vesical pains, dysuria, excretion of sand particles, ammoniacal odor, and the abundant secretions, etc.

4th. Retention of urine disappears under the amelioration of those symptoms; but the em-

ployment of the catheter ought occasionally to be continued, should the bladder not completely empty itself.

5th. Several of the patients observed had used the customary remedies—as turpentine, tar, mineral waters, etc. The stigmata of maize have produced good results when the means previously used had not benefited.

It may be useful in certain cases to employ at the same time with the stigmata the external measures indicated by the pathology—as vesical irrigations with much water, by the double current catheter; also injections of solutions of tar, borax, silicate of soda; those of bicarbonate of soda if the urine be acid, or those of benzoic acid if it is very alkaline.

6th. Besides their effects in bladder affections, the stigmata produce the best results as a diuretic, entirely harmless, though very energetic in heart affections, albuminuria, and in general in all cases in which ordinary diuretics are indicated. We have known numerous cases in which the urinary secretion has trebled or quintupled in the first twenty-four hours, and others in which the medicine had been continued two and three months without any untoward result. It is to be stated that the diuretics most in use, as nitrate of potassa, digitalis, squills, etc., are not always convenient, or without risk.

Urethral Chancroid; Cicatricial Stricture.

The following case is reported in the Buffalo *Medical and Surgical Journal*, for August, 1880, by Henry P. Cooke, M.D., Assistant Surgeon U. S. Marine Hospital Service:—

F., seaman, aged twenty-seven years, placed under treatment January 9th, 1880, for chancroid of penis, and a discharge from the urethra. On examination a small lump was found in the urethra abut 1¾ inches from the meatus, and it was believed that the discharge arose from a chancroid located at this point within the canal. January 24th patient complained of symptoms of stricture of the urethra, which was found to be located in the seat of the chancroid above described. The chancroid having healed, treatment for the stricture was instituted by the method of gradual dilatation, which was continued until a No. 6 sound could be passed. Beyond this point the use of the sound produced no effect, and another chancroid appearing on the glans penis, treatment was suspended until it should have healed. From the latter part of February to April 20th, patient was lost sight of. At the latter date he again appeared with the chancroid still existing, it having assumed the serpiginous type, and for this he was treated until June 27th, when it finally healed. Examination now showed a tight stricture, through which it was impossible to introduce a No. 1 catheter. By the use of a filiform bougie, small silver probes, and finally a catheter, dilatation was carried to the extent of admitting a No. 1 steel sound, and from this it was gradually extended until No. 3 could be introduced. Beyond this it was found impossible to proceed, and divulsion, with Thompson's instrument, was attempted, patient being under the influence of ether. The instrument was turned until the index marked about No. 4, when with a sudden snap it broke, the shoulder against which the point of the lever rests having been pried from its bed in the groove of the shaft. Subsequent to this, two separate attempts were made, with the same results, although the instrument was repaired very thoroughly after each accident. As the stricture was too tight to admit Maisonneuve's urethrotome, it was decided to attempt to incise it from within, with an ordinary tenotome; and to this end the patient was etherized, a grooved director introduced, and a long-bladed tenotome made to follow the groove until the stricture was reached. With the knife inserted up to the shoulder of the handle, the stricture could be touched with only a small part of the cutting edge, and with this it was nicked until a No. 4 sound could be passed. Maisonneuve's instrument was now introduced, and the blades separated until the index marked 40, when the knife of the instrument was drawn through the stricture, and the urethrotome removed. A No. 12 sound was immediately passed, and the treatment by dilatation commenced. The resistance of the stricture was shown by the fact that the lower blade of the urethrotome, a powerful instrument, was bent several lines out of position; and when the knife passed through the stricture the sound was that produced by cutting hard-rubber cartilage.

Congenital Atresia of the Vagina.

The following case, under the care of Mr. R. T. Leeming, is reported in the *Lancet*, July 3, 1880:—

M. A., aged nineteen years, married eighteen months, was admitted on January 16th, 1879. She had never menstruated, but suffered from pains in the back and around the abdomen for several years.

On examination a hard tumor larger than a fœtal head was found in the abdomen immediately above the pubes, and instead of a vagina there was a large rounded protrusion, covered with mucous membrane, tightly stretching the vulva. Examination per rectum proved that the abdominal tumor and vaginal protuberance were one.

An opening of three-quarters of an inch was made in the centre of the vaginal protuberance, and the confined menstrual discharge came away in the form of a very thick treacly fluid, to the extent of over two quarts. The parts were covered well with carbolic oil. Two days later the incision was extended toward the meatus urinarius and perineum. On digital examination there was a perfect vagina and os uteri. A tent of carbolic tow was introduced, and external antiseptic dressings were used. The patient had a restless night, and on removing the dressing next morning about half a pint of albuminoid leucorrhœal discharge escaped. There were no symptoms of constitutional disturbance until the second night after the operation, when the patient had several rigors. At 10 A.M. temperature was 103° F. On the dressing being removed a quantity of fetid pus, but of a laudable color, escaped. On examination with the speculum this discharge was seen welling from the uterus, the os being dilated to the size of a threepenny piece, the parts being

swollen. The vagina also participated in the general inflammatory action. The glands in both groins were enlarged and very tender on pressure. Instead of the ordinary dressing a speculum was now introduced and fixed, filled tightly with carbolic tow, so that the discharge might escape. Five grains of quinine, with ten drops of sedative solution of opium, were administered every four hours.

The inflammatory fever lasted for four days, the temperature, mornings and evenings, varying from 100° to 102.° The secretion now became of an albuminoid nature, which soon ceased with a subsidence of the irritative fever and swelling of the inguinal glands.

Before leaving the hospital, about three weeks after the operation, a normal menstrual flow took place.

The case was entirely lost sight of until April 29th, this year, when on a journey into the country Mr. Leeming met her medical attendant, who informed him that the patient had been delivered of a full-grown female child, after a natural labor, three days previously. Mr. Leeming visited her, when her expression of countenance, instead of being dull and half idiotic, as previous to the operation, was bright and intelligent, and she said that after she left the hospital she was quite a different woman, and had never been so well.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Dr. J. L. Gerhart, of Hot Springs, Arkansas, sends us, in the form of a reprint from the St. Louis *Medical and Surgical Journal*, June 20th, 1880, a paper on "The Therapy of the Waters of the Hot Springs, and their Relation to the Medical Profession at Large."

——We have received, in a reprint from the *Journal of Nervous and Mental Disease*, for April, 1880, a paper on "The Coincidence of Optic Neuritis and Subacute Transverse Myelitis," which was read before the New York Neurological Society, March 2d, 1880, by E. C. Seguin, M.D.

——"Physicians and their Patients," is the subject of a lecture delivered at the formation of the Douglas County Medical Institute, April 22d, 1880, by C. H. Merrick, M.D., which has been sent to us in pamphlet form, and in which the lecturer discusses their true relation in a very able manner.

——We have received the prospectus of the *Rocky Mountain Medical Review*, a new medical journal, to be published monthly, at Colorado Springs, Colorado, the first number to appear in September next. It will be edited by A. Wellington Adams, M. D., assisted by several other gentlemen. Subscription Five Dollars per annum, in advance. We wish the enterprise success.

——"The Ship Origin of Yellow Fever, with Comments on the Preliminary Report of the Havana Yellow Fever Commission," and "Practical Hints Relating to Yellow Fever Prevention," are the respective titles of two pamphlets by Robert B. S. Hargis, M. D., of Pensacola, Florida, sent us, the one in a reprint from *Gaillard's Journal*, for June, the other from the *Independent Practitioner*, for July, 1880.

——*The North American Review*, for August, contains the following interesting articles:—"Ruined Cities of Central America," by the editor; "The Law of Newspaper Libel," by John Proffatt; "Nullity of the Emancipation Edict," by Richard H. Dana; "The Census Laws," by Charles F. Johnson; "Principles of Taxation," by Professor Simon Newcomb; "Prince Bismarck, as a Friend of America, and as a Statesman"—Part II, by Mortz Busch; "Recent Literature," by Charles T. Congdon.

BOOK NOTICES.

Transactions of the Medical and Chirurgical Faculty of the State of Maryland. Eighty-second Annual Session, held at Baltimore, Md., April, 1880. pp. 213.

The inaugural address, by the President, Professor S. C. Chew, A.M., M.D., was on the subject of "Medicine, in the Past and in the Future." Prof. John W. Mallet, M.D., of the University of Virginia, delivered an address on the "Claims of Science, for its Own Sake, upon the Medical Profession." The following are among the papers read: "The Use of the Sphygmograph in Practice," by Abram B. Arnold, M.D.; "A Novel Case of Hemorrhage During Labor," by P. C. Williams, M.D.; "Report on Sanitary Science," by James A. Stewart, M.D.; "What Can be Done for our Imbeciles," by J. D. Thomson, M.D.; "Optico-ciliary Neurotomy," by Julian J. Chisolm, M.D.; "On the Extraction of Cataract Within the Capsule"—based on 200 operations after this method—by George Reuling, M.D.; "Clonic Spasm of the Muscles of the Arm and Trunk," by Randolph Winslow, A.M., M.D.; "The Use of Caustics in Dermatological Practice, with Special Reference to the Treatment of New Growths," by I. Edmondson Atkinson, M.D.; "Diagnosis of Malignant Tumor of the Upper Jaw in Youth," by L. McLane Tiffany, M.D. A list of the members is also appended.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE REGISTRATION OF DISEASE.

From time to time we have referred to the growing recognition of the fact that mortality tables are no fair gauges of the healthfulness of a given period of time or community. There are numerous diseases which prevail very extensively at times, or are of an obstinate character and persistent duration, which, however, are attended with very little fatality. Mumps, measles and varicella are examples of the former; the lighter forms of malarial fever, skin diseases, nervous diseases, and probably syphilis, of the latter.

Some striking examples were quoted by Dr. John W. Moore, of Dublin, in a paper he read last winter on this subject.

Thus Mercatus asserts that before the beginning of autumn, in the year 1557, influenza attacked all parts of Spain *at once*, so that the greatest part of the population in that kingdom were seized with the disease almost on the same day. At St. Petersburg, in the epidemic of 1782, Maertens says, that on a cold night the thermometer rose 30 degrees Fahrenheit, and next morning 40,000 people were taken ill with the influenza. We can readily imagine what serious consequences might possibly attend outbreaks of sickness such as these, although they would not necessarily leave their mark upon the statistics of mortality.

Again, under ordinary circumstances the prevalence, or otherwise, of an endemic disease stands in no direct relation to the published returns of mortality attributed to it. The argument in favor of registration of disease deducible from this fact applies *à fortiori* in the instance of an epidemic, where the ratio of cases to deaths is of a most varying and uncertain character.

Difficulties, no doubt, stand in the way of carrying out an effective system of disease registration, but they are not insurmountable, and the fact that several European governments have long since inaugurated and prosecuted such a system should encourage us in essaying to follow their example. In the vanguard of progress in this direction the Scandinavian nations occupy the place of honor.

For many years back the College of Health at Stockholm has received monthly and annual reports of the sanitary state of the country, including an account of the prevailing endemic and epidemic diseases, from a corps of officially appointed medical men, styled provincial and district physicians, subsidized by the State. The monthly reports furnished by these physicians are published from time to time in the Swedish medical periodical, *Hygiea*, while the annual returns are compiled and arranged by an official whom we may call the Swedish Registrar General, and are finally presented to the king in the form of a volume of official reports and tables.

A similar organization exists in both Norway and Denmark—so far, at all events, as relates to the registration of epidemic diseases. In the "Weekly Report of Diseases, Deaths, and Births, in Copenhagen," communicated by Dr. P. A. Schleisner, Medical Officer of Health, and published by authority of the Municipal Council, the first table gives the cases of epidemic and con-

tagious (infectious) diseases reported to him by the medical men practicing in the Danish Capital. The notification of these affections is compulsory.

The effort is earnestly in progress in Great Britain, to make the report, at least of all contagious and infectious diseases, compulsory.

The scope of such a report is given in the following extract from the proposed bill:—

"Every medical practitioner attending on or called in to visit such inmate shall, on becoming aware that such inmate is suffering from any such disease as aforesaid, forthwith fill up, sign, and deliver to the occupier or person having the management or control of the building, or, in case such person is suffering from such disease, to the person in charge of such inmate, a certificate stating, according to the forms prescribed and supplied to him by the corporation, the name of such inmate, the situation of such building, and the name of such occupier or person, and the nature of the disease from which such inmate is suffering."

It would be more satisfactory and congenial to Democratic tastes, were this done generally by physicians, without the fear of law before their eyes.

Why would it be impossible so to impress the practitioner of medicine with the importance of the information that he would, at the close of each week, fill up a printed form giving the new cases, of all kinds, which had come under his care during the week? Nearly all physicians keep such records, and their tabulation would be the work of less than half an hour in quite an extensive practice. Certain errors, as of duplicating cases, etc., could readily be eliminated.

Such weekly reports, forwarded promptly to some central office of the county, properly digested and published, would infallibly prove of the highest utility, and offer the authorities the means of providing far better for the general health than do the present inefficient plans.

MEASURES AGAINST TRICHINOSIS.

Several severe outbreaks of trichinosis, some resulting in the death of a number of individuals, occurring not only in Germany but in England, have led the medical authorities of European States to take measures of greater vigilance for the protection of the people against this disease.

Certain insidious forms in which it appears seem also to justify the supposition that it is more frequent than is generally supposed, and is very liable to be mistaken for some common complaints. Thus it is by no means easy to differentiate certain cases from typhoid fever. The general symptoms and course of the disease to a fatal conclusion may be deceptively alike. No doubt, not a few cases of supposed typhoid, arising in country localities, for which the family and the physician searched in vain for an existing cause, were in fact trichinous disease.

Another form in which it is sometimes found assimilates muscular rheumatism. The limbs are stiff and painful, and may remain in this condition for a long time.

When in an acute form, after the ingestion of considerable trichinous flesh, the attack is of the gravest character. No practically valuable suggestions as to its treatment appear to have been made. Ergot, kerosene and oil of turpentine have been from time to time brought forward as alleged destructives of the parasites; but their claims have not been substantiated by clinical experience.

The only safeguard is to adopt thorough and rigid preventive measures, closely examining the flesh of hogs when slaughtered, and rejecting all that is found to contain trichinæ. This is what has been done abroad. It is announced from Berlin that, in consequence of the numerous cases of trichinosis recently observed, the authorities of that city have taken very severe steps concerning the execution of the measures for the inspection of pork exposed for sale. This inspection is carried out with the aid of a microscope; and the following are the measures now adopted in Berlin: Whoever slaughters a pig, or has one slaughtered, with the intention of selling its meat, or of making any kind of sausage with the meat, is bound to have it examined after slaughter by an inspector of meat, who with the aid of a microscope assures himself of the presence or absence of trichinæ. The meat cannot

be cut up, except after the certificate of the inspector has been given, affirming that it is exempt from trichinæ, and after the inspector's seal has been put upon the slaughtered animal. Any contravention of this order is punished by a fine of three to thirty marks, or imprisonment.

With our present laxity in sanitary laws, it were hopeless to expect that such strictness as this would be countenanced, even though the health of the public were jeopardized by the neglect of such precautions.

Fortunately, the authorities are of accord that thorough cooking will destroy the vitality of the parasite, and this is a precaution all can take. Smoking and salting the flesh only partly does away with its toxic qualities. These measures cannot therefore be depended upon. A temperature at or above the boiling point is needed. As the trichinæ are very rarely found in any other flesh used for consumption than that which is derived from swine, eaters of this should make it a rule to insist on its being extra "well done."

Notes and Comments.

Therapeutical Notes.

THYMIC ACID MIXTURE FOR DIPHTHERIA.

Dr. Jos. H. Warren; of Boston, writes, in the *Virginia Medical Monthly*, that he has for the last few years been using the following medicine in all of his cases of diphtheria and diphtheritic sore throats, with a success that he never attained with any other form of medication:—

℞.	Glycerine,	℥ ij	
	Thymic acid,	gr. iv to vj	
	Chlorate of potash,	℥ iiss	
	Bi-sulph. quinine,	℥ ss to ℥ j	
	Brandy (very old),	℥ vj	M.

Sig.—To a child from two years up to five, a teaspoonful every hour or two, according to the urgency of the disease. Increase the dose from this age upward, to ℥ iv. Let the patient take it without any water, if possible, as by so doing he will get the stimulating effect on the throat, and thus avoid the use of anything for a gargle.

This is, says he, a fine formula to use as a prophylactic agent for this disease, and malaria and other affections of similar origin.

By adding a few drops of the muriated tincture of iron to each teaspoonful or dose, we have one of the very best of tonics, and it will be found useful in many cases after typhoid fever, attended with diarrhœa, or in ulceration of the mucous membrane of the stomach and bowels. If the food distresses it will be of great advantage if we add a few grains of true pepsin porci, of Muson's, or ingluvin, manufactured by Warner & Co.; particularly the latter medicine, in atonic dyspepsia and some forms of chronic indigestion, accompanied with nausea after taking food.

For atomizing the throat he uses the following formula:—

℞.	Glycerine,	℥ j	
	Thymic acid,	gr. vj to x	
	Borate of soda,	℥ iv	
	Camphor water,	℥ iv	
	Tar water,	℥ v.	M. Filter.

Sig.—Atomize freely every two or three hours.

The glycerine is added to cut the thymic acid and hold it in solution.

PHOSPHATE OF ZINC IN DIARRHŒA.

According to *Bull. Gen. de Thérap.*, May 15th, 1880, M. Tedenat usually employs this salt of zinc in preference to the nitrate, chiefly on account of its greater insolubility in the acid juices of the stomach. Its action as a remedy in diarrhœa is the same as that of the nitrate, but the dose is less—1–2 grams. It may be given in precisely the same way as the nitrate.

BALSAM OF PERU IN PRURITUS.

In a communication to the *Deutsche Med. Wochen.*, Dr. Auerbach, of Berlin, states that having, in common with so many other practitioners, found the balsam of Peru a most valuable remedy in itch, he has for some time past used it in the treatment of pruritus with the greatest success. After the first rubbing into the part affected great relief is obtained, and in a few days a cure results. He relates a very obstinate case which, after resisting all kinds of treatment for years, was speedily cured by the balsam.

The Arciform Fibres of the Medulla Oblongata.

The *Lancet*, July 24th, 1880, states that M. Luys has made an interesting communication to the Société de Biologie on the subject of the connections of the arciform fibres of the medulla oblongata. He maintains that they are nothing more than the terminations of the inferior cerebellar peduncles. After these have reached the lateral parts of the medulla, the fibres pass obliquely into this region, and increase its size by passing between the ascending fasciculi from the spinal cord. Some of the fibres, however, pass into the interior of the medulla, and these are the concentric fibres which form so conspic-

uous a feature in all transverse sections of the medulla. That part of the fibres which apparently remains on the external surface of the medulla, and extends on the restiform bodies and anterior pyramids, presents great variations in direction and terminal distribution. Some of the fibres surround the olivary bodies, and penetrate the median raphe; while others have a serpentine direction toward the pons. The conspicuous fact regarding these fibres is that, whatever be their course, all seem to decussate at the middle line, and this decussation in fact constitutes the median raphe, the significance of which has not been accurately estimated. The ultimate destination of these fibres is still uncertain. M. Luys thinks it probable that, after decussating they enter one of the deposits of gray matter which are seen close to the raphe, and which are composed of large cells with interlacing processes. Others probably pass to the network of cells of the olivary bodies on the side opposite to that on which they entered the medulla from the cerebellum. In support of these views, he showed sections from a case of congenital atrophy of one lobe of the cerebellum. The inferior cerebellar peduncle on that side was completely atrophied, and so also was the olivary body on the opposite, which contrasted strikingly with the full development of the olivary body on the same side. This important observation speaks strongly for the view advanced by M. Luys, that there is an intimate connection between the olivary bodies and the cerebellar fibres.

Septic Embolism of the Eye Occurring in Puerperal Fever.

Hirschberg is of opinion that the metastatic inflammation of the uveal tract has not as yet sufficiently engaged the attention of ophthalmologists. He has observed six cases in all, in three of which both eyes were affected, and describes minutely in *Archiv f. Augenheilkunde*, vol. ix, 3, the symptoms and post-mortem appearances in one which he was able to follow almost from the beginning. The patient, aged 34, whose puerperal attack came on sixteen days after the birth of her third child, complained on the twenty-first day of great pain in the eye; thirty-six hours afterward the condition was as follows: Slight chemosis, cornea clear, semilunar-shaped hypopyon covering half the breadth of the iris below; pupil semi-dilated under atropine, central exudation on the anterior capsule, leaving a clear margin, V = fingers at 2′. Next morning complete blindness of right eye. The left, which was unaffected the day before, was now almost blind. With the ophthalmoscope a medium-sized hemorrhage could be made out, surrounded by a grayish-white area, "a septic embolism of a small retinal vessel, certainly of only a few hours' standing." Next day complete blindness and a copious thick exudation covering the iris. Death on the thirty-second day after confinement. At the post-mortem examination the right eyeball was opened, and the retina found to be destroyed by suppuration and the vitreous infiltrated with pus. The left was hardened in Müller's fluid and examined microscopically after some months, when the principal changes were found to be in the retina. The embolic nature of the intra-ocular process was first demonstrated by Virchow, while the septic character of the embolism has been made out by Heiberg and Litten. The difference between ordinary septic embolism is thus put by Hirschberg: "Ordinary embolism causes sudden blindness of the affected eye, accompanied by the well known ophthalmoscopic appearances, and ends in atrophy of the optic nerve and retina. Septic embolism, whether of a retinal or choroidal artery, rapidly gives rise to a disturbance of vision, usually associated with a veiling of the fundus, and ends in suppurative inflammation of the retina, vitreous, choroid, iris, etc. With septic embolism of a very small branch some amount of vision may be retained for some hours or days, until suppuration in the fundus brings about complete blindness; aseptic embolism of the same branch might, under certain circumstances, completely escape detection."

The Structure of Spermatozoa.

The *Lancet*, July 24th, 1880, informs us that in the current number of the *Quarterly Journal of Microscopical Science* is a short paper by Dr. Heneage Gibbes, in which he states that he has found the spiral filament discovered by him in the spermatozoa of several species of animals, as the rat, mouse, axolotl, pigeon, fowl, snail, and leech. In the examination of different specimens of human spermatozoa, he has noticed a variation in the length of the tails, and in one specimen he found a number of heads with no corresponding tails. He throws out the suggestion that these variations may have some important bearing. It is quite possible that tailless spermatozoa may not be able to fertilize the ovum, while the greater the length of the tail the greater their locomotion and fertilizing power may be. Dr. O. S. Jensen, of Bergen, has found the spiral filament in the semen of horses; and Professor

Fleming, of Kiel, has also confirmed Dr. Gibbes's observations, both as to the existence of this filament, with its mesentery, and the different reaction to staining fluids of the head and middle part of spermatozoa.

The Constituents of Tobacco Smoke.

The *British Medical Journal*, July 17th, 1880, informs us that MM. G. Le Bon and G. Noel, in a recent note communicated to the Paris Académie des Sciences, assert that they have extracted from tobacco smoke, 1. Prussic acid; 2. An alkaloid, having an agreeable odor, but dangerous to breathe, and as poisonous as nicotine, since a dose of one-twentieth of a grain destroys animal life; 3. Aromatic principles as yet undertermined, which contribute, with the abovementioned alkaloid, to give to tobacco its characteristic odor. MM. Le Bon and Noel say that tobacco smoke owes the toxic properties attributed hitherto solely to the nicotine contained in it, as much as to the other substances they have discovered in it. The alkaloid pointed out seems to be identical with the compound known as collidine, of which the existence had already been noted in the course of distillation of several organic substances, but of which the toxic and physiological properties were overlooked. Collidine, however, plays a fundamental part in tobacco smoke; and it is to its presence that certain kinds of tobacco, comparatively poor in nicotine, and yet very strong in smoking, owe their properties.

Digital Compression of Aneurisms.

Dr. Pize, in *Bulletin de Thérapeutique*, April 30th, 1880, condemns the teaching of Bellingham and Broca, to the effect that total compression gives rise to the formation of soft or passive clots in an aneurism, while partial compression favors the formation of solid fibrinous clots, which alone conduce to repair. The author advocates the retention of digital compression during the first twenty-four or forty-eight hours, after which it should be intermitted at night, to allow the patient to sleep. He considers that total digital compression offers advantages over any other means of treatment, inasmuch as (1) it is not dangerous; (2) it is more rapid in its action; (3) it is more often successful, and gives more brilliant results; (4) it has succeeded in cases in which partial compression has failed. He says that the reason why this treatment is most successful is because it most conduces to coagulation of blood within the aneurismal sac.

Acid Reaction in Animal Tissue.

Marie Ekunina describes, in the *Journal für Praktische Chemie*, an investigation conducted in Prof. Nencke's laboratory at Berne, on the causes of acid reaction of the animal tissues after death. This reaction is attributed to the decomposition of tissue juices, after death, by fungi. Volatile fatty acids first arise through commencing decomposition of albumen, but very soon the two lactic acids proceeding from glycogen are associated with these. The richer the tissue in carbo-hydrates, the longer does the acid reaction continue after death; this is especially the case with liver, muscles, and lungs. The shortest and weakest acid reaction is that in the pancreas. Sooner or later, in all tissues, the acid reaction passes over into an alkaline, while the decomposition of albumen increases, and there is much formation of ammonia.

Correspondence.

The Habit of Making Believe.

Ed. Med. and Surg. Reporter.

"It is the practice of acting as if the creations of the physician's imagination were realities, without ascertaining whether they were so or not, that has proved so fatal to the progress of medicine; and it is only through the diligent comparison of ideas with facts, by observation and experiment, that we can hope for its advance."

This quotation is the concluding paragraph of Dr. Lauder Brunton's first Goulstonian Lecture before the Royal College of Physicians, in 1877. The truthfulness of the statement—that fancy had held the place which knowledge should hold—is quite plain, and it is a lamentable fact that the same statement is to a great extent correct, if applied to the modes of thought and practice of the present day, especially as to the so-called malarial diseases. Fancy, imagination, hypothesis, have been about the entire stock of materials of which our so-called malarial pictures have been constructed in our minds. On page 10, loc. cit., Dr. Brunton gives this: "We know that if a man pass through certain districts, and more especially if he sleep in them, he is likely to be attacked with a fit of shivering, which, often lasting some time, will be succeeded by a burning fever and then by profuse sweating, after which he will feel comparatively well until the next day, when another shivering fit will come on at the same hour, and run the same course as the first. We know that by warning the man against the dangerous locality, or by making him adopt certain precautions, take cinchona alkaloids, if he cannot avoid the place, we may be able to prevent the disease; by administering one large dose of quinine before a paroxysm we may stop its approach, and by continuing the remedy we may prevent its occurrence altogether. But we are ignorant

of the nature of malaria, as we term the cause of these paroxysms, whatever it may be. We do not know how it acts on the bodily mechanism, so as to cause them. We have no notion of the manner in which quinine counteracts the malarial effects, or why quinine should sometimes fail and arsenic prove efficacious." * * * * * * * * * *

We may say that the immediate cause of the ague fit is probably due to the intense irritation of the vaso-motor centre in the medulla oblongata, but we have no idea of the nature of the irritant, and we cannot even guess why the irritation should occur at regular intervals. We do not know the changes in the nervous system and tissues which occur during the intermissions, and we are utterly at a loss to explain why a man should come from a malarious district in India and die of jungle fever in England, although he had never had it while abroad and it is never seen in residents at home."

The language quoted presents some important thoughts and facts, but it gives only a part of the facts which bear upon the subject of the malarial diseases; it does tell the truth, but not the *whole* truth. A man exposed, as stated, to the Pontine marshes, for instance, may present other symptoms than those of intermittent fever; he may have a choleraic attack, a diarrhœa or dysentery, a headache, a catarrh of the mucous surfaces; he may be attacked even with a fatal pernicious congestion, as it is termed; or he may have a continued fever; or he may only suffer from general malaise, or from chronic malarial cachexia in the course of time, without having had any previous urgent symptoms.

The language of Dr. Brunton plainly shows that it is built upon the fancy of a certain specific organic germ, or something as being the cause of the malarial diseases. His idea of the disease is narrowed and distorted by his fancy as to what constitutes its cause. If the symptoms he gives included all the manifestations of malarial disease—all the primary and direct manifestations—it would be reasonable to believe, to imagine at least, that the cause of it was a specific organized germ; but the symptoms he gives the disease which he states as being likely to follow certain exposure is but a very small, although a very misleading part of the *whole* truth.

The language given is misleading in another respect; it says, "a man passing through certain districts, and more especially if he sleep in them, etc., etc." We are led to infer that it is only in certain relatively small districts that the cause of the disease exists, which we know is contrary to the facts. In at least one-half of the whole territory of the United States, if a man expose himself to the burning heat of the sun during the day and the shock of cold winds and moisture during the night, *especially when asleep*, he will be attacked by precisely the same disease as when exposed to the influences of the "certain districts" alluded to by Dr. Brunton; and what is more striking yet, he never will take the disease mentioned unless he is subjected to great variations and extremes in temperature and humidity, and when he is thus subjected he hardly ever escapes, whatever "certain districts" he may be in or "passing through."

It is quite apparent that the fancy of a specific germ, as being the cause of the malarious diseases, causes us to have so narrow a view of this subject as to prevent us from seeing more than a very small fraction of the *whole* truth. The import of the statement in regard to "*a man* being attacked by *intermittent fever* upon passing through certain districts, etc., also is that *any man* so passing through, etc., would be thus affected, which is contrary to the facts; only such as have acquired *l'aptitude ou l'imminence morbide* from climatic influences are in danger of becoming thus affected. A man in good health, from the mountains of Switzerland, passing at once from his home through these "certain districts," sheltering himself from the heat of the sun during the day and the chill of the air at night, maintaining a good blood pressure, will escape the disease in question, while the man whose *tone* has become depressed will have great difficulty to prevent the disease, unless he resort to artifical means to maintain his blood pressure at a healthful point by the tonic influence of the cinchona alkaloids, etc.

Another objection to the statement "that if a man pass through certain districts," etc., he is likely to be attacked, etc., lies in the matter of time when the probable attack may occur. The inference would be that it will appear promptly, and that if it does appear at all it will do so after the lapse of about the same period of time in all cases, which is contrary to the facts, as Dr. Brunton himself states in the case of "a man dying of jungle fever in England, although he never had the disease in India."

Toward the close of the lines quoted from Dr. Brunton's book, we find this: "But we are ignorant of the nature of malaria," etc. If this means to say that we are ignorant of it, as to its being a specific organized germ, we can all readily agree, and what is more that can be truly proclaimed is, that we shall so remain ignorant. But if we add the last clause, "whatever it may be," then we submit there is no foundation for the statement. If we do not *know* anything that has not been impressed upon our minds by way of one or more of our five external senses, then we can at once admit that we do not *know* the nature of malaria, and can also safely assert that we never shall *know*. But if we *know* that we have mind, intellect, reason, feeling; if we *know* anything that has come to our knowledge not by way of our external senses; if we *know* the physiology of the vaso-motor ganglionic and sympathetic nervous system, and its reflex activities, and if we know the surroundings which stimulate, irritate or impress and depress this sensitive organism, then we do *know* what causes the so-called malarial diseases.

And all that follows the quotation last referred to is so plainly shaped and colored by the fancy of a specific organized germ, by the "wrong method" which Dr. Brunton laments and labors to remove, as being one of the causes of the slow progress of medical science, that we are fully convinced "that this practice of making believe" (see page 16) is not a mere childish folly unworthy of a moment's consideration, but the outcome of a deeply-rooted tendency of the hu-

man mind, and therefore deserving of most serious attention." It caused Dr. Brunton to "make believe" that we do not know what we really *do know* as well as it is possible to know a physiological or pathological fact of this nature.

Shelbyville, Ill. CHARLES T. REBER.

NEWS AND MISCELLANY.

Why We Eat Oysters Raw.

We take the following from the London *Medical Record*, July 15th, 1880:—

Dr. William Roberts, in his interesting lectures on the digestive ferments, states that our practice in regard to the oyster is quite exceptional, and furnishes a striking example of the general correctness of the popular judgment on dietetic questions. The oyster is almost the only animal substance which we eat habitually, and by preference, in the raw or uncooked state; and it is interesting to know that there is a sound physiological reason at the bottom of this preference. The fawn-colored mass which constitutes the dainty of the oyster is its liver, and this is little else than a heap of glycogen. Associated with the glycogen, but withheld from actual contact with it during life, is its appropriate digestive ferment—the hepatic diastase. The mere crushing of the dainty between the teeth brings these two bodies together, and the glycogen is as once digested without other help by its own diastase. The oyster in the uncooked state, or merely warmed, is, in fact, self-digestive. But the advantage of this provision is wholly lost by cooking; for the heat employed immediately destroys the associated ferment, and a cooked oyster has to be digested, like any other food, by the eater's own digestive powers.

How the "Finest Wines" are Made.

The *Medical Times and Gazette* informs us that the German Government, hearing that the wine-growers of Baden, in the face of several successive years of defective vintage, were actually manufacturing an increased quantity of the "finest wines," instituted inquiries which resulted in the discovery that large quantities of spirit have been imported into Baden (not direct, but by circuitous means), to be manufactured, bottled, and sold as the real product of the German grape. The police have suddenly appeared upon the scene, and the Government seal has been affixed to a great number of casks of supposed genuine wine which are to be tested by the public analyst. One great house, which has hitherto enjoyed public confidence in an unlimited degree, is said to be marked out for prosecution. It appears that this firm has done business to the amount of 500,000 marks since the beginning of the present year, and the police are in possession of evidence that it has purchased no less than 300,000 marks' worth of foreign spirit in an underhand manner. It is stated that the German vintagers have obtained from Paris a "clever artist" who has proved that it is just as easy to produce chemical hocks as chemical clarets.

The Salubrity of the Isthmus of Panama.

The following interesting note, says the *British Medical Journal*, was presented at the *séance* of the Académie des Sciences of Paris, held on June 28th, by M. de Lesseps: "Much has been said lately on Panama, especially in the United States, about the yellow fever existing there. The rare cases of this fever that do occur there prove that the disease neither originates nor spreads in the district. Several ships with numbers of patients on board suffering from very characteristic yellow fever, arrived lately. There being no one authorized to prevent passengers from the infected ships landing, they have done so, and pretended that those who died of the disease from which they themselves were suffering were victims to the climate. There are no sanitary precautions and hygienic rules at Panama, any more than at Colon. Nevertheless, the fever imported has not spread beyond the persons affected before their landing. This is surely evident proof of the salubrity of the Isthmus of Panama, which, from its situation between the two oceans, receives in turn and without intermission the healthy breezes of the Atlantic and of the Pacific."

Dr. Tanner at the Completion of his Fast.

Probably no man has ever been more anxiously waiting for the sound of the breakfast bell than Dr. Tanner was last Saturday. For several days he had been in an extremely critical condition. His weight was reduced to 121½ pounds, showing a loss of thirty-six pounds since he had taken his last meal. As soon as the clock struck twelve he eagerly devoured a peach, which he had been fondling for more than two hours, and washed it down with a glass of milk. He next ate a large piece of watermelon, and during the afternoon he ate several pieces, swallowing the juice only. He also had some beefsteak and several glasses of Hungarian wine, his stomach showing no indication of rebellion, and he stated that in two days he would be able to walk about and attend to his business as usual.

OBITUARY NOTICES.

—Professor Paul Broca, the eminent anthropologist and statesman died suddenly, at midnight, July 8th, at the age of fifty-six years. "The surprise and deep regret," says the *Lancet*, "which this unexpected event created, not only in the medical but in the general public, can only be appreciated by those who knew how deep an influence the celebrated Professor had obtained over the minds of those who in France lead an intellectual life."

—Dr. Stephen H. Ward, for many years physician to the Seamen's Hospital, Greenwich, and to the Hospital for Diseases of the Chest, died at his residence, No. 28 Finsbury Circle, of disease of the heart and liver, on the 10th of July.

MARRIAGES.

GLASGOW—McPHEETERS.—At Fincastle, Va., June 30th, by Rev. D. W. Shanks, Dr. Robert Glasgow and Kate L., daughter of the late Dr. A. B. McPheeters.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1225.] PHILADELPHIA, AUGUST 21, 1880. [Vol. XLIII.—No. 8.

Original Department.

Communications.

THE SUMMER DISEASES OF CHILDREN.

BY WILLIAM B. ATKINSON, A.M., M.D.,
Lecturer on Diseases of Children, Jefferson Medical College, Philadelphia.

(*Continued from p.* 114.)

In the inflammatory form of diarrhœa in children, we have added several symptoms of more or less significance. The common name *Dysentery* is generally employed to signify difficult or painful evacuations.

The causes of this form of alimentary trouble are usually the same as those which occasion ordinary diarrhœa. We frequently have added an epidemic tendency, during the prevalence of which nearly every case of diarrhœa speedily assumes an inflammatory condition. We shall not attempt to explain this phenomenon, or to give the causes aiding to produce it, except to say that where outbreaks of this disease occur within circumscribed limits, as in a boarding-school, a children's home, etc., they may almost positively be placed to the account of bad drainage or the use of impure water.

The disease very generally begins like an ordinary attack of the non-inflammatory form, and very often is but a sequel of a continued diarrhœa. The evidences of the presence of inflammation are the usual febrile symptoms—acceleration of the pulse, increased heat and dryness of the skin, thirst, loss of appetite, great tenderness over the bowels, frequent evacuations, accompanied by more or less straining and distress, which, however, is but slightly if at all relieved by the discharge from the bowels. The face of the little patient shows, by its pallor, with frequent flushings, emaciation, and its drawn, worn expression, the suffering under which the child labors, as well as the gravity of the disease.

When the seat of the inflammation is in or near the rectum, the desire to defecate is constant, which act is accomplished only by powerful straining, often to such an extent as to cause an eversion of the lower portion of the bowel, and a feeling as though there yet remained a foreign body which had not been forced away. This, which is known as tenesmus, may be, and generally is, associated with tormina or griping pains, which cause a great increase of suffering.

The stools, while frequent, are small in quantity, at first consisting of lumps of feculent matter, scybala, mixed with mucus, more or less tinged with blood; and when the disease becomes chronic, pus is present.

As the disease progresses the surface becomes cool, the pulse feeble and rapid, the straining less, by reason of the inability of the little patient to make much effort; the patient lies in a semi-comatose condition, which may end in complete coma, convulsions and death.

Should the fatal ending be delayed, the abdomen sinks in, or in some cases it becomes tumid, and feels to the child as though it were burning; excoriation of the anus occurs; the discharges become extremely offensive, often with a cadaveric odor; frequently the amount of blood is greatly increased, and in some cases the evacuation appears to be wholly composed of mucus and blood.

From the above it would seem to be an easy task to diagnose the presence of dysentery, but

instances constantly occur where great alarm has been caused by the announcement of dysentery, or inflammation of the bowels, where the blood in the discharges was due to hemorrhoids, injuries about the anus, or even to affections of a more serious character, as malignant diseases of the rectum, etc. Straining may be due also to the presence of a foreign body in the rectum, and therefore, unless a number of symptoms prove the nature of the attack, it is well to examine the little patient with great minuteness before pronouncing upon the case.

The treatment depends greatly upon the period when the physician is called, and the train of symptoms then present.

It has been the almost invariable custom in the early stage of dysentery to give the child a dose of castor oil, on the ground that we thus cleanse out the alimentary canal. While a purgative would thus enable nature to rid herself of such matters as are keeping up the irritation, yet in too many instances it is too late, and the bowels really need rest rather than increased action. Again, the remedy is one which is so repugnant to the majority of patients that it is advisable to avoid its employment. In the form of the oleaginous mixture it seems to have proved of great value in many instances. We thus exhibit the remedy in a less disagreeable form, and may continue it in small doses, at short intervals.

The following is a useful formula:—

℞. Olei ricini, f. ʒ iij
Tinct. opii, ♏ xij
Mucilag. acaciæ,
Syr. simplicis,
Aq. menthæ viridis, āā f. ʒ j M.

Dose.—Teaspoonful every three or four hours.

Where the oil is objectionable we may employ the effervescent citrate of magnesia or the Rochelle salts, either of which act mildly but efficiently. When free discharges have been thus produced, we may find that the only remaining treatment requisite will be rest in the horizontal position, bland and nutritious food, and perhaps some form of tonic.

Much comfort is always obtained by the free use of light poultices to the abdomen; to these, hops, or a decoction of poppies, may be added with great benefit. In the employment of poul tices, care is requisite that they do not become a source of irritation and discomfort by their weight and the wetting of the child's clothes and bedding. Make a poultice light, let it cover the entire abdomen, put it on always between cloths, and so folded that the contents shall not be spread in every direction, and rather dry. The warm bath or warm sponging of the entire surface will prove of equal value, but in the use of these means the necessity of rest in the recumbent position must ever be borne in mind, as otherwise, we may cause more injury than benefit.

In this connection we desire to urge upon the attendants a point which is constantly neglected. Children are permitted to rise on the slightest feeling of a desire for an evacuation, and sit upon the commode and strain with great force for a long period. This must be prevented. Let the patient evacuate in a bed-pan, or, preferably, with very small children, in a gum cloth, while it lies in the horizontal posture. Insist that it shall avoid straining, and where this act appears almost beyond its control, great and almost immediate relief may be obtained by the passage of a small pointed piece of ice into the rectum. We have rarely seen this to fail, whether with children or adults. In lieu of this, the anus and adjacent parts may be frequently bathed or sponged with cold water. Some practitioners claim to have had equal, if not better effects, with warm water.

The engorged rectum may be aided to unload its vessels, also, by the free injection of cold water at intervals. Enemata have long been a favorite remedy in this condition, and may consist of starch or mucilage in small quantities, say a tablespoonful, or even a teaspoonful with a small quantity of some medicament added. We shall allude to this more at length hereafter.

The food and drinks must be bland, mucilaginous, and in small quantities, and at short intervals.

The treatment is to a great extent similar to that of diarrhœa in any form.

The subnitrate of bismuth combined with the compound ipecacuanha powder will generally prove of service, and should be employed as before indicated. As mentioned previously it is of great importance that symptoms of cerebral trouble should be watched for and guarded against. When such indications present, opiates should at once be withdrawn, and revulsives employed, as the hot mustard foot bath, cold applications to the head, the bromides and chloral, to prevent convulsions, at the same time guarding against a sudden collapse of the vital powers from exhaustion.

Acetate of lead has long been regarded as a favorite astringent in this form of disease. It is generally combined with opium and ipecacuanha, as in this formula:—

℞. Plumbi acetatis, gr. vj
Pulv. ipecac. comp., gr. ix
Sacch. alb., ʒ ss. M.
Ft. in chartulæ No. xij.

Dose.—One every three hours, for a child of one year.

Where irritability of the stomach is present we have found the lead to be objectionable by the mouth, and prefer to omit it entirely, or use it in the form of enema, with starch or tincture of opium.

Undoubtedly, ipecacuanha is of great value in this affection. Some practitioners prefer to employ it alone, while others combine it with such a variety of remedies that it becomes difficult to decide to which the credit of the cure should be given. We prefer it either in the form of the compound ipecacuanha powder, or with opium or hyoscyamus, and prepared chalk—

℞. Pulv. ipecac., gr. ij
Pulv. opii, gr. j
vel Extracti hyoscyami, gr. ij
Cretæ præp., gr. xxiv. M.
Ft. in chart. No. xij.

Dose.—One every two or three hours, to a child of two to five years.

The effect of the remedy should be carefully watched, and the dose increased or diminished according to the indications. These powders are best administered in milk, to which a little sugar may be added, if desirable.

In this affection, while we watch with the utmost care for any cerebral symptoms, and would on their approach urge the immediate discontinuance of opium, yet we must acknowledge that we rarely encounter a case without feeling the urgent necessity of this remedy in some form. Frequently we have obtained the most satisfactory results from the camphorated tincture of opium, in a full dose, after each evacuation. To a child of two to five years we would give twenty drops, and repeat as indicated. Where there are symptoms of exhaustion, the aromatic spirits of ammonia may be added, or brandy may be given in the form of milk punch, etc. Twenty to thirty drops of brandy, well diluted, may be administered to a child one or two years of age, every two or three hours. In some cases alcoholic stimulants do not agree, and are liable to produce sickness of the stomach. Here the ammonia is preferable. This may be employed in doses of two to five drops, in a teaspoonful of syrup and water, every hour.

When the symptoms begin to yield, as a tonic and astringent we have for many years employed the solution of nitrate of iron. In fact, in the diarrhœa of both children and adults we have found this article of great value.

To a child of one year we give one drop every three hours, in syrup, and as before mentioned, in combination with a bitter, as the tincture of gentian or of columba. When needed this may be used at the same time as one of the other formulæ, for checking the bowels.

It would seem almost unnecessary to allude to the need of proper nourishment, were it not that this is too often utterly lost sight of. Beef tea, or raw meat cut very fine and mixed with sugar, should be given in small quantities at short intervals.

Finally, it must be remembered that in all these forms of intestinal trouble there is a great tendency to a relapse, a renewal of the disease, and it becomes of the utmost importance to avoid for some time the use of any food liable to cause irritation, as well as to see that the patient is not exposed to cold and dampness.

THE EVOLUTION OF CONSCIOUSNESS.

BY HORATIO R. BIGELOW, M.D.,
Of Washington, D. C.

"What weight can we attach to a man's philosophy, who, after telling us that consciousness may possibly be an inherent property of matter, of which 'the receipt of reason is a limbec only,' adds in the same breath almost, that matter generally is certainly not conscious, and that consciousness comes to the brain we know not whence nor wherefore? What shall we say of a man who in one sentence tells us that it is impossible that science can ever solve the riddle of things, and tells us in the next sentence that it is doubtful if this impossibility will be accomplished within the next fifty years? Who argues that God is a mystery, and therefore God is a fiction. Who admits that consciousness is a fact, and yet proclaims that it is a mystery; and who says that the fact of matter producing consciousness being a mystery, proves the mystery of consciousness acting in matter to be a fact?" ["Is Life Worth Living," by W. H. Mallock.] This reference to an address by Professor Tyndall, is the substance of a footnote to chapter ix, "The Logic of Scientific Negation," of Mr. Mallock's masterly thesis. I could wish for nothing better in the great struggle of enlightenment than that this book might be in the hands of every one interested in the drift of modern positivism. It is well conceived and admirably carried out. Its logic is keen, its sentences terse and clearly cut, its

deductions unimpeachable. To physiologists it is of especial interest, because upon the results of cultured physiological inquiry will rest the ultimate rise or fall of positivist theory.

It is not within the scope of the present article to discuss the question of Truth and Happiness—whether the possession of the former conduces to the latter, or whether the attainment of the latter will necessarily rest upon the former—though he who ministers to a mind diseased must be intimate with the various phenomena which go to make up the action of the mind in health. It is apparent, however, that these terms have no permanent value, since their definition must vary with each one's interpretation, and since their demonstration in fact is not possible. The mystery of the supernatural enwraps them, just as it enwraps the mystery of life itself. There is a point of "inchoate consciousness" at which all scientists have confessed themselves arrested, and it is just here where the modern school of skepticism will ask us to accept an idealistic theory in lieu of the faith which they decry in matters of theological polemics.

Never was human parturition so fraught with agony as is the labor of a positivism—limited because finite—striving to give birth to an intellectual conception of the Incomprehensible, which, being infinite, in the sense of not being material, may never be measured by finity. Just at the point where matter ends and mind begins we are asked to accept a scientific creed, belief in which will entail a larger amount of faith than Christianity demands of its adherents. If consciousness be evolved from a surrounding conscious nature, to which it shall return, we should expect to find in that nature a harmonious perfection—the consummation of truth. No one, as yet, has ventured to offer so untenable an explication. Nature, in her inconsistencies, horrifies us at every turn. Is consciousness, then, the result of molecular change in the brain, or does the presence of consciousness cause the molecular change? It may not be questioned that the brain is the organ through which consciousness is made manifest; and this admission is entirely consistent with theistic doctrine. But if it be argued that the outcome of cerebral molecular change is consciousness, then should the physical processes be complete in themselves, and go on and on with the same integrity as now, even were consciousness absent. Dr. Tyndall says: "Do states of consciousness enter as links into the chain of antecedence and sequence which gives rise to bodily actions? * * * I have no power of imagining such states interposed between the molecules of the brain, and influencing the transference of motion among the molecules. But the production of consciousness by molecular action is quite as unpresentable to the mental vision as the production of molecular motion by consciousness. If I reject one result I reject both. I, however, reject neither, and thus stand in the presence of two incomprehensibles, instead of one incomprehensible." [Quoted by Mallock.]

The only possible and rational explanation of the existence of consciousness is the belief that the brain is the natural organ, attuned by supernatural fingers; and since inherent potentiality in matter is not demonstrable, and molecular motion cannot originate of itself, and never has so originated, it requires a less degree of faith to believe that "such states are interposed between the molecules of the brain, influencing the transference of motion among the molecules,' than to believe that the production of consciousness is due to an inherent, indestructible property of the molecule to originate that motion which we call consciousness. The existence of the material and of the immaterial or spiritual are unconsciously admitted by Dr. Tyndall. The first incomprehensible, of molecular motion, is material; the second incomprehensible, of consciousness originating molecular change, is immaterial. Neither result does Dr. Tyndall reject, hence he must tacitly accept that "interpretation of grosser minds," that "heathen notion," of a soul. At this threshold, where through the gate that is half ajar there streams an effulgent ray from the Infinite Himself, the Professor views his own insufficiency, and confesses that he does not reject the theory of the supernatural. The fashioning of our own consciousness presupposes an infinite power of creation out of a Supreme Consciousness, to which our immortality is allied. This potentiality has not been given to man, and a self-conscious molecule is a scientific vagary unworthy consideration. "Every thought and feeling has its definite mechanical correlative, that is accompanied by a certain breaking-up and re-marshalling of the atoms of the brain." [Dr. Tyndall.] This may be granted without reservation, but can Dr. Tyndall tell us whether the chemico-molecular action precedes thought, or whether a power which is as yet to us a mystery induces the molecular change the outcome of which is thought? Can the chemist analyze it? Can the microscopist define its characteristics? Can the physiologist tell us just what reactions of mole-

cules are necessary to perfect certain trains of thought? Will any positivist trace out the cerebral conditions, together with the chemical formulæ, engendering that condition which will lead us to the attainment of his consummation of morality—happiness?

In every department of exact inquiry there is an unconscious appeal to the supernatural, and positivists are constantly making use of terms which are absolutely devoid of meaning, unless a belief in the supernatural be implied. No man can explain the nature, cause and end of consciousness. Its unprejudiced contemplation leads up higher and higher, until in the presence of its Infinite Creator we find that peace and consolation which is the comforting assurance of an immortality in which we shall know as we are known.

In this hope is the Christian's creed. Theirs is no impossible ideal, no theoretic fancy, that truth for truth's sake is heroic, and that the end of human life is a happiness, which, be it said, no positivist confesses as yet to have attained. Their Truth finds its ultimate consummation in the contemplation of the Infinite Truth, and their happiness lies in immortality.

But to admit that in consciousness we have a proof of a spiritual governance, were to abjure the whole positivist creed; and hence we are asked to accept as explanatory a premise in every way most unscientific.

Until it may be demonstrated that molecules may so interact as to produce consciousness, it is nobler, as it is more logical, to confess our inability to trace its cause, and to believe, what may not be disproved, that a Higher Power governs it, and that by its presence molecular change is engendered.

INFRA-HYOID BRONCHOTOMY.

BY T. H. MANLEY, M. D.,
Of Lawrence, Mass.

On the morning of the first day of April, of this year, at an early hour, I was called to see a man whom the messenger said was dying. Without inquiring what the circumstances were that led to this condition, whether they were from accident or disease, I started off with all possible haste. Reaching the man's bedside, I found him vomiting with violent expulsive effort, and without the power of uttering a single audible syllable, so great was the difficulty in breathing. And what particularly struck me was that as the retching continued, between every short interval of rest the stridor was increased. Every expiration produced a loud whistling sound, with the ring of true croup. I was told that he had drank, through a mistake, about twelve ounces of lime water.

It appears that having some stomach derangement, he was in the habit of drinking an infusion of oatmeal and water every night, and that he would commonly rise, and during the night allay his thirst with a large draught of this mixture.

On the occasion under consideration it seems that the previous evening some one placed in his pint pitcher a lump of unslaked lime, about the size of a duck's egg, without his knowledge, and after giving the vessel a few turns with his hands, to mix the supposed meal, he swallowed nearly the whole before he discovered his mistake; then commenced the vomiting and suffocation.

After the history of the case was hastily given me I quickly left the room for another, to prepare an antidote to meet the alkali. Milk and sweet oil being near at hand, in the want of anything better I prepared a cupful, equal parts, of these two liquids. In a moment I returned with this to the patient; but it was of no avail, he could not swallow a drop. Finding my efforts futile in this direction, I returned to the kitchen for ice, intending to fill the mouth and envelop the neck with it, hoping by this means to control the violent congestion caused by the corrosive action of the lime.

I was scarcely five paces from the bedside when the frightened attendant (a female) called me back. To my surprise and horror, I found the man on the floor in, as it seemed, the agony of death, from suffocation. There he lay, the tongue protruding through the thick foam that filled the mouth, the eyeballs bulging from their sockets, the face distorted, swelled and discolored, the pulse gone at the wrists, the hands cold, and the expression that of a man struggling desperately for life.

Taking the whole in at a glance, and believing that it would be all up with him if immediate relief were not rendered, antidotes were not to be thought of for the time, and the only thing offering any gleam of hope was the keen-edged scalpel. But where was my assistant? The only man about, the one who came for me, had disappeared. The women, in trepidation and terror, had left the chamber, and to call a surgeon with a view of assisting me at that hour (3 A.M.) was absurd to think of. Realizing the critical situation in which I was placed, I decided to make a bold move that would at least ease the patient's sufferings, if it did not save his life. With this determination, I placed the lamp

on a chair, laid the man squarely on his back, and gave him to understand that the slightest move on his part would interfere with my efforts to give relief; then picking up a common strong scalpel, I entered the larynx with two free strokes of its blades making an incision about two inches wide.

The change that followed was no more sudden than amazing. All consternation on the patient's part passed off. The dusky hue left the cheeks, the tongue was returned to the mouth, and the pulse again beat in the radial arteries. The features assumed an aspect of ease, and the breathing, though through an artificial opening, was not embarrassed.

However, the danger was not yet over; bleeding commenced in earnest, and I knew that danger lay in prostration from excessive hemorrhage and from blood escaping into the air passages from the divided vessels and interfering with respiration. After all immediate danger was past, I sent for a surgeon with the experience obtained from a long period of military service in the late war of the Rebellion, Dr. C. N. Chamberlain, to assist me in controlling the hemorrhage, etc.

The doctor very kindly immediately responded to my call. With his skillful aid the bleeding was soon completely checked. We inserted a silver tube, through which the patient breathed, packing the space between it and the edges of the wound with fine moist sponges, to prevent any oozing of blood or mucus.

At 8 A.M. alarming collapse set in; however, after an injection of six ounces of whisky it gradually passed away. No trouble was encountered after this, with hemorrhage; the great difficulty was in nourishing the patient, who did not retain injections well. After the operation for the supply of air, we had to keep in mind the inflamed state of the œsophagus, and stomach. Accordingly, after subduing the faucial or throat congestion by the liberal use of ice, we closed the opening in the metallic tube, and caused the patient to swallow a large quantity of milk and castor oil. Four hours after the operation, by closing the tube, sufficient air passed through the mouth to the lungs to supply the man's wants, showing conclusively that the inflammation and tumefaction of the glottis and surrounding parts had subsided, and that the tube was no longer needed, and the surgeon only to sustain the strength and heal the opening.

The points which I regarded in this case as of sufficient interest and importance to be placed before the profession are, first, the situation; secondly, the direction of the incision; and lastly, the harmless effects in the intestines of the large quantity of lime drank.

Remembering the urgency of the case, that there was no assistant of any description about, it became necessary that the opening should be made where it could be done with the most celerity, and where there was the least liability to dangerous bleeding. The man being of a short build, with a thick, fat neck, it would be useless, without any assistance or tracheotomy tube, to open the windpipe low down. Again, in this section the carotids pass dangerously near the trachea, on their way to the cranium. So that to hazard an incision in this locality, in a dimly-lighted room and alone, would be hardly justifiable.

The man being forty-five years old, to open his well ossified larynx with an ordinary scalpel was impossible; accordingly, acting on the judgment acquired while interne in the Park Hospital, New York, in the treatment of wounds of the neck inflicted with suicidal intention, I quickly made "*a transverse incision between the hyoid bone and the thyroid cartilage of the larynx.*" This brought me down below the obstructions in the pharynx, and by the contraction of the divided muscular fibres secured a permanent opening without the necessity of using retractors; besides, it allowed of the opening with the least hemorrhage. There was little, except from the small transverse branches of the superior thyroid artery. No tissues to divide except the skin, fat, one ribbon-like muscle, the platysma, and the fibrous membrane that connects anteriorly the hyoid bone with the thyroid cartilage of the larynx. The margins of the muscles passing nearly vertically close to the median line were necessarily wounded. After the introduction of the tube all bleeding ceased, but it having to be passed down between the vocal chords caused great pain. So, though contrary to the suggestion of my consultant, I removed it as soon as it appeared to me possible to dispense with it with safety. Its early removal likewise contributed to accelerate the healing of the wound. While in, it was continually filling with mucus and impeding respiration, so much as to require one to stand by all the time and keep it swabbed out. On account of the opening being so high up, during the act of deglutition it became necessary to press the edge of the wound together, else the liquids would leak through.

I am not able to explain the exact phenomenon of this occurrence, but I suppose it was due

to a derangement of the suction apparatus of the pharynx. I have seen the same thing occur when the wounds were self inflicted. After the first week, when the wound began to close, this disagreeable leakage ceased. After five weeks' treatment the wound was completely healed (no antiseptics used, or disinfectants, except pure water, pure air, and clean linen), and there is nothing to be seen on the neck to indicate a previous mutilation of tissue, except a small scar about the circumference of a small pea. He says he can breathe and swallow as easily as ever, and from appearances certainly there is nothing to indicate that he is telling an untruth.

In the evening following the accident he passed, by the rectum, large quantities of lime, in small lumps. Why this should have excited such violent inflammation at the primary orifice of the alimentary canal and none at its middle and lower parts, I cannot understand, unless that it spent its strength at the outset on the first mucous membrane it came in contact with.

As soon as I reached home, after leaving the patient, I examined my text-books, and could find no description of an operation for bronchotomy done in this region. I was about to give up in despair the search for an author to support my course, when I found a paragraph in "Malgaigne's Surgery," wherein the author "proposes" the operation of "Infra-hyoid-Bronchotomy" in cases of grave diseases, or foreign bodies in the larynx. In describing the different stages of the operation, he says, "It has not yet been performed on the living subject."

Though I found little or nothing published to justify my course, still I was, and am now, convinced that the circumstances were such as allowed of no other means of immediate relief. Why, I thought to myself, will not my patient recover, when in many suicidal cases I have seen the trachea and œsophagus completely severed and the patients survive?

Here it will be observed that without any previous acquaintance with the particular operation, I did it successfully, acting on the dictates of common sense, without which time proves that books and blades are of little use.

I am positive in this case nothing could have been done that offered my patient so good a chance of life, and me so ready a method of entering the air passages.

I offer this article for publication with the hope of getting some light on its literature, and to inform the profession of a method of opening the larynx seldom heretofore performed by surgeons.

GLEANINGS FROM PRIVATE PRACTICE.

BY C. C. VANDERBECK, M.D., PH. D.,

Of Allentown, N. J.

What a peculiar attraction clinical reports or lectures have for the mass of medical readers! It were folly to debate the value of such reading. All know the peculiar opportunities of hospital study and work; and many of the best modes of treatment of private practice of to-day, both surgical and medical, as well as numerous instruments and appliances, had their origin in the wards of hospitals. Yet, is it not true that all over our broad land many a medical expert lives and plies his vocation in small towns and rural districts? Is it not true that many a peculiar and interesting case occurs in the countryman's practice?—one that would prove of interest even to city physicians as well as to some fellow rural doctors? Who has talked with different doctors of the country but has found out that they often possess novel ideas, and good ones, too, of treatment, or of some surgical appliance? So, Mr. Editor, while you give space for the "clinics," will you for a time let me seek to group on paper such useful ideas, hints and operations as I may gather from physicians removed from clinics and hospitals.

During a recent conversation with Dr. Junkin, of Easton, Pa., some useful ideas were given as regards women's diseases. In using nitrate of silver for the inner membrane of the womb, in lieu of a porte caustic, he uses a platinum wire of sufficient length, coating the end thoroughly with the silver, and in this manner: Grasping a piece of silver nitrate with a pair of tweezers, hold it near a flame from a spirit lamp, while the opposite hand holds the end of the wire in the flame until hot enough to pierce for some distance the silver. Allowed to cool, the nitrate will be found firmly fixed on the wire. In order to make this point of proper size and shape, pass it through the flame quickly, which softens the medicine, and allows it to run as the wire may be turned or held. This part of the procedure is the most difficult, for unless care is used, the entire piece of silver will fall off. After a few trials, however, one will become expert in making these points. In the application of this to the inside of the uterus the wire must be properly curved, and *quickly* passed through the neck into the body of the womb. Any delay in the neck causes immediate contraction and foils or makes difficult the passage of the instrument into the body.

The way the doctor came to describe to me

this instrument is this: I was asking advice in a case of severe and protracted menorrhagia. Examination proved the trouble to be in the uterine mucous membrane. In such cases he has had excellent results from these points, used once a week. I tried it, and so far with gratifying results, having arrested the bleeding for three weeks—the longest period for a year or more.

Dr. Junkin thinks that menstruating females are not cleanly enough. After each period tepid water should be injected high into the vagina, washing out all debris. He thinks that the irritation of retained clots and mucus is one of the causes of uterine disease. Does this really not look reasonable? How many do it? How many physicians advise it? In maidens, of course, it is a little inconvenient to use a syringe, but the efforts put forth will certainly bring back good interest in health and hardiness. We are living in a hygienic age. More attention is given every year to the care of health and prevention of disease. Will not our teachers of hygiene insist upon cleanliness of the sexual organs? Yet, it will be as hard to get it done, I imagine, as it is to get people generally to use the morning cold sponge-bath. Can anything be more grateful than the glow and vigor obtained from this morning application of water? It is quite possible, if we heard more of water for the uterus, we would have less to do with platinum, zinc, and nitrate of silver.

Dr. Junkin recommends young physicians to use the bivalve speculum. He says the common glass ones often discourage the inexperienced. With them it is more difficult to find the os, and to explore the uterine cavity, especially if there be any malposition.

There is a class of women in the country who get through their confinement cases without medical aid, depending upon the old women, especially those who have had "many of them," of the vicinity. Just such cases as fall to the lot of the student to learn from in the cities, or are attended by the district physicians. All is well that ends well, but if it don't end well what then! In other words, if by the lack of medical aid and attention a life is sacrificed, it may be the mother, or it may be the child, where does the responsibility rest? Should not every township have its recognized "poor" doctor, who would attend such cases for a small cash fee, to be paid in all possible cases by the family. It should be obligatory on all poor families to secure the services of a physician; if very poor to obtain the required services at poor rates; if in very destitute circumstances, to obtain town aid. That is, no confinement case should be allowed to occur without the services of a medical man. Less of these *no doctor* cases would happen, I feel sure, if the patient knew that services could be secured at a small price, without the stigma of becoming a pauper. In our township of Upper Freehold, no regular poor doctor is appointed by the committee. The pauper can select a physician, and the overseer then arranges for attendance. Or the family calls for its physician, and he, for protection, asks the town aid for them. Charity attendance needs a little regulation in the country as well as in the city. It seems to me, the remedy is the appointment of a town physician by the committee, and after it is clearly shown that a family is unable to pay regular fees, that they may secure the advantages of the poor rates, which should be very much reduced from regular charges. A late case in my practice will serve to illustrate the evil of no attendance in confinement. About midnight, not long since, I was called to see an Irish woman in labor. While riding to the house the boy who came after me remarked that the women thought the child was dead, but he could tell me nothing more of the case. I found on arrival that the baby, a large, well formed, female child, was born and dead. The old women said it was born after the boy started to town for me, and was dead when it came into the world. I came to the conclusion that the birth occurred before the boy left at all for me. The women had mismanaged in some way, and finding a dead child on their hands, sent for a doctor, so as to secure at any rate a burial certificate.

Will some of your readers give me the probable cause of the prominence of one eye just previous to an epileptic attack, in a case of mine? I do not mean a few moments before, but it often serves as a warning one or two days before the attack. It is true it is not always followed by a "grand mal," but it is a premonition of the epileptical "bad days." It is well known that epileptics enjoy periods of variable length of comparative freedom from unpleasant symptoms, followed by days of mental and physical distress—symptoms of reflected nervous irritation in almost all the organs of the body, diarrhœa, nausea and vomiting, backache, headache, dizziness, "petit mal," and mental feebleness. Even as a precursor of these evil days have I noticed, in the case referred to, the prominent left eye, giving a peculiar and alarming expression to the face. Tanner, in his most excellent "Manual of Clinical Medicine and Physical Diagnosis,"

under the caption of "Signs Presented by the Eye," says, "The eye may be increased in size, from hyperæmia of its tissues, such as takes place in impending suffocation, or in congestion of the brain, heart, or lungs; it also becomes more prominent, and therefore apparently increased in size, in convulsions, apoplexy, epilepsy and delirium tremens." Now, what I want to know is, what is meant by the eye being "more prominent, and therefore *apparently* increased in size?" Is there turgidity of the surrounding tissues in the condition causing this prominence of the eye? Will this symptom guide me to a suitable plan of treatment to relieve the sufferings of the "bad days?"

A late number of the *American Agriculturist* considers the subject of "Fatal Accidents from Mowing Machines," especially those resulting from drivers being thrown off from their seats in front of them. Country physicians can substantiate these statements, not only as regards the frequency of accidents to the driver, but to children who are playing in the field and running behind the machine. Two sad accidents occurred to girls in our vicinity last summer in this way, the foot being severed from the leg in each case.

As remarked before, this is an age of hygiene; and noble efforts are now put forth to prevent disease. What shall we call efforts to prevent accidents? It is a subject worthy of more attention than has been given it. Should not physicians carefully examine all instruments and mechanisms dangerous to life, and see whether their danger could be diminished without any special curtailment of use and power. The *Agriculturist* says that a lady of Burlington, N. J., invented an arrangement for throwing the knives of a mowing machine out of gear the instant the driver's weight was taken from the seat. It knows of no instance of its being put to use. Could not the inspecting and reporting of the different machines, their respective dangers, and how they could be thus improved, be the duty of boards of health?

It has been a matter of surprise to me that country physicians do not make more of the various operations on the teeth. As a rule, they are not adequately supplied with extracting instruments, and by reason of this, so often fail to perform a good job at extracting, that they become timid, and hesitate to undertake the work. A few carefully selected instruments, including a good root, right and left molar, and an incisor forcep, will make one master of the majority of cases. As some one in a recent issue of the REPORTER suggested, we should not be timid and cowardly about the various minor operations. Especially in districts without a dentist, should the doctor be prepared to relieve suffering by lifting out an offending tooth. But more, why, in such regions, could not the physician save teeth that the ignorant patient asks to have removed, by filling them with some of the usual preparations. I am not asking a doctor to turn dentist; but the doctor can pick up many an extra dollar by being not too particular in his work, in fact, by performing his whole duty, saving tissue, relieving suffering and deformity, bestowing comfort, aiding nature. Let us illustrate: A bright damsel came to my office to have four badly decayed teeth removed, which done, she asked if I could not clean her teeth. That is, she wanted the ugly collection of tartar on the upper front teeth removed. I went to work with the end of a match and some very fine powdered pumice stone, and using care not to injure the enamel, in less than an hour the teeth were looking clean and polished; and she was greatly pleased with the change, and paid me an extra dollar or two for my services. In small cavities, where gold is not required, and no "building up" necessary, why cannot a doctor easily learn to put in a simple amalgam filling. Often being asked by my patients after extracting what is good for the teeth as a dentifrice, I show them a tooth powder, put up in what is called a magnesia bottle, and usually sell them a bottle, and thus further add to my income.

Gentlemen, I am not ashamed to write of little things, if I can suggest to the struggling, plodding, hard-worked (or under-worked) little-paid doctor how to add to his pocket-book some dollars.

God bless the country doctor! Yea, often is it God pity the country doctor! No thousand dollar fee ever drops into his coffers. Even down to the sale of a bottle of tooth powder must he descend for that which is to keep his family in even a degree of comfort. Wake up then, brother, glean all you can. It is all legitimately your due. The dentifrice I referred to above is:—

℞. French prepared chalk,
Powd. borax, āā ℥ viij
Powd. orris root, ℥ ij
Powd. cinchona bark, ℥ iv
Powd. castile soap, ℥ iij.
Oil wintergreen sufficient to impart an agreeable perfume. M.

Before closing, let me give a few formulæ I have found useful. Great account is now made of "Rock and Rye," and advertisements are

constantly seen in the papers. I make my own, thus:—

℞.	Rock candy,	1¾lb
	Boiling water,	1 pint
	Best rye whisky,	2 quarts.

Stir, and after the candy is dissolved, or saturation is reached, strain.

A good liniment for some purposes, especially where iodine is useful, as in tumors, etc., is this:—

℞.	Iodine,	gr. x	
	Alcohol,	℥ iv	
	Water of ammonia,	ʒ j	
	Camphor,	℥ ij	
	Tinct. red pepper,	℥ iv	
	Ol. lavand.,		
	Ol. rosemary,	āā ʒ j.	M.

To make a successful worm liquid add santonine to fl. ext. of spigelia and senna.

I have found sol. acetate of ammonia, in tablespoonful doses every hour until the pain is relieved, an excellent remedy for dysmenorrhœa. Sometimes the stomach is so irritable that I cannot carry out this plan to full effect, but where it is retained it has given great satisfaction.

I am using very much of the deodorized tincture of opium, and find it superior by far to any other preparation of opium. Scarcely ever does it produce nausea and headache. It is more reliable in strength than laudanum as usually kept by druggists. Many druggists make their laudanum, one ounce of opium to the pint of dilute spirits. The officinal directions are, two ounces and a half of opium to two pints of dilute alcohol.

It seems to me that we do not appreciate the value of nux vomica as we should. I have carefully examined a file of 7000 prescriptions in a country drug store, and not one called for nux vomica. I can testify to the valuable tonic properties of the following:—

℞.	Tinct, cinch., co.,	℥ iv	
	Tr. nucis vomicæ,	ʒ j.	M.

Sig.—ʒ j ter die.

I know not whether it is generally known that spirits of nitre is a good solvent of salicylic acid:—

℞.	Salicylic acid,	℥ ij	
	Spts. nitre,	℥ j.	M.

Dose.—One to two drachms.

I think it is often forgotten that corrosive sublimate is moderately soluble in cold water, and that dilute alcohol, or even a weaker spirit still, will dissolve it. Thus in bed-bug poison, (trusting the reader may not have occasion for practical use of it) a cheap mixture, and an efficient one is—

Corrosive sublimate,	1 ounce
Chloride of ammonia,	½ ounce
Dilute alcohol,	1 quart.

Corrosive sublimate forms, with chloride of ammonium and chloride of sodium, compounds which are more soluble than the uncombined mercurial salt. It is on this account that aqueous solutions of sal ammoniæ, or of common salt, dissolve much more corrosive sublimate than simple water. The above formula could be changed to one quart of water, and yet be found to accomplish the solution of the poison.

A good mucilage for office use is made thus:—

Gum arabic,	1 ounce
Glycerine,	2 drachms
Boiling water,	3 ounces.

I suppose every country physician keeps a number of recipes written in a little blank book, for reference. In this same book, anything new he hears or reads of is put down. The objection to an ordinary book is the difficulty in finding just the formula wanting when in a hurry. I find a small-size book-keeping ledger very convenient, and make an entry in the alphabetical pages, of every formula or item copied into the book. For instance, in "T" is Tooth Powders, page 40, and on turning to this page, the formula given above is found. Try this plan, and find what a convenience it is, and what a pleasure it gives to have one's knowledge thus classified. It is somewhat after the style of Todd's advice to make an "Index Rerum" of all things of importance in one's reading or experience. In this manner may the work of a lifetime be saved, controlled, and reviewed.

Hospital Reports.

MERCY HOSPITAL, CHICAGO, ILL.

REPORTED BY GEO. W. MASON, M.D., HOUSE PHYSICIAN.

Prevailing Diseases and their Treatment.

As a basis for this my report concerning the diseases which are most prevalent in Mercy Hospital, their peculiarities and their treatment, I have taken the records of cases occurring in the medical department, from the first of September, 1879, to the first of March, 1880. During this period the cases most frequently treated have been phthisis (both fibroid and tubercular), rheumatism, periodical methomania, and typhoid fever. Of common but less frequent occurrence have been gastric troubles of different kinds, idiopathic erysipelas and diphtheria.

In the treatment of all patients the greatest care is taken to provide them with the best hygienic surroundings possible. The hospital contains both private rooms and general wards. The

former are for the accommodation of one, and not more than two patients, and vary in size from ten by fifteen feet, to fifteen by fifteen feet, with the ceiling thirteen feet high. The general wards are so arranged that the average space for each patient is from 1500 to 1800 cubic feet. The windows are so arranged as to give the freest ventilation. All the beds are furnished with hair mattresses. After use by a patient that could by any means cause infection of the same, all the bedding is at once thoroughly disinfected by being baked at a temperature of 200° F., in a special oven, constructed in the hospital for that purpose. All the rooms are frequently and thoroughly cleansed. These conditions are provided for all patients.

Phthisis.

These cases have been mostly tubercular, but a few of them were diagnosticated as fibroid. No local peculiarities have been noted, save that the climate of the city is adverse to their improvement. This is ascribable to the proximity of the lake and to the fogs which occur here. The object of the treatment has been to avoid medication as far as possible, to surround the patient with the best hygienic conditions, and to promote nutrition. To this end he is directed to wear sufficient clothing, especially flannel, next to the skin, during all of the year, except a few weeks in the warmest summer weather. His room is given free ventilation. When the weather is suitable he is encouraged to take as much exercise in the open air as is possible without a sense of exhaustion. Extreme inflation of the lungs is practiced several times a day. Baths, in water of an agreeable temperature, are taken two or three times a week. No particular diet is prescribed, but nutritious articles of food in large quantities are recommended. Tonic medicines are avoided, and are used only in urgent cases. Maltine, cod-liver oil, and the compound syrup of the hypophosphites are given freely. An elegant preparation is the combination of maltine with cod-liver oil. Many patients are able to take this mixture when they reject the oil by itself. All these remedies are used at the same time, the first two in the combination given above, and the hypophosphites separately.

Palliative treatment is prescribed only as needed. For persistent troublesome cough, with difficult expectoration, we use our "muriate of ammonia mixture," of which the following is the formula:—

		Gms. or c.c.	
℞.	Ammonii chloridi,	12 00	
	Antimonii et potassii tartratis,	0 13	
	Morphiæ sulphatis,	20	
	Syrupi glycyrrhizæ,	125 00	M.

Sig.—Teaspoonful every four hours.

This mixture is used continually, for coughs of all kinds, with the most satisfactory results. In extreme cases of phthisis, where the cough cannot be controlled by other means, a combination of the oxalate of cerium and the subnitrate of bismuth, in the form of a powder, has afforded much relief. When night sweats occur, alum baths, or aromatic sulphuric acid, atropia, or spiritus frumenti at bedtime, are the therapeutic remedies that are resorted to. An irritable stomach is treated with the "carbolic acid mixture," which will be described in another place. But all kinds of medicines are used as little as possible.

Rheumatism.

The subacute form is that which has most frequently presented itself for treatment. This has taken the usual course, with an occasional pericarditis or endocarditis complicating it. In the treatment of it the usual care has been taken to provide the patient with pure air and to protect him from exposure. Among medicinal agents, the salicylic acid has been most extensively used, according to the following formula:—

		Gms. or c.c.	
℞.	Acidi salicylici,	15 00	
	Sodii bicarbonatis,	10 00	
	Glycerinæ,	30 00	
	Aquæ, q. s. ad	128 00	M.

To this the tincture of digitalis is added when there exists cardiac complications, and the tincture of veratrum viride when the febrile reaction is very pronounced. This has been alternated with the mild chloride of mercury combined with Dover's powder and the nitrate of potash. The salicylic acid, however, does not seem to be entirely devoid of harm. While it reduces temperature, lessens the morbid sensibility, and moderates the circulation, it has at the same time, in not a few instances, so much weakened the heart's action that its use had to be discontinued. Better results have been obtained by combining the iodide and bromide of sodium or potassium with colchicum and cimicifuga:—

		Gms. or c.c.	
℞.	Potassii iodidi,	10 00	
	Potassii bromidi,	20 00	
	Vini colchici radicis,	30 00	
	Tincturæ cimicifugæ,	60 00	
	Aquæ, q. s. ad	125 00	M.

Sig.—Teaspoonful.

As with the former prescription, veratrum viride is added if indicated. Local applications for the most part have been abandoned, because they have not seemed in any way to modify or shorten the course of the disease; this is especially true of alkaline fermentations. Counter irritants are discouraged, because the metastasis which is very likely to occur may take place to the heart, causing an endocardial or pericardial inflammation. When a remedy of this class is indicated, the skin over the part affected is painted with a mixture of one part each of croton oil and the tincture of iodine, and two parts of ether. This has been found to be very serviceable when applied over the præcordial space, in the case of cardiac irritability and distress.

Gastritis.

Cases of chronic gastric disturbance are quite common in the hospital. They present themselves in all degrees of severity in both the diffuse and follicular varieties. In the treatment of these cases, the diet consists of such articles of nutritious food and in such quantities as the individual's stomach will tolerate. This is determined by trial in each case. Among therapeutic agents, by far the best results have been obtained from the use of a "house" pre-

scription which we designate the "carbolic acid mixture":—

		Gms. or c.c.	
R.	Acidi carbolici,	50	
	Glycerinæ,	15 00	
	Tincturæ gelsemii,	15 00	
	Tincturæ opii camphoratæ,	60 00	
	Aquæ,	60 00	M.

Sig.—Teaspoonful.

This is given just before each meal and at bedtime. Its mode of operation is easily understood. The carbolic acid is antiseptic, and in the small doses used, sedative. It allays the morbid sensibility of the stomach. The gelsemium and camphorated tincture of opium operate in the same direction. It forms a preparation that is not at all disagreeable to the taste. The persistent use of this mixture has rarely failed to give relief even in the most obstinate cases of chronic gastritis. It has also proven very serviceable in gastric acidity or irritability occurring in the course of other affections, such as rheumatism, phthisis, cardiac diseases, etc. In exceptional or extreme cases various combinations of the subnitrate of bismuth, bicarbonate of soda, and the subcarbonate of iron are used, or resort is had to rubefacients or vesicants applied to the epigastrium.

Typhoid Fever.

With us it runs the usual course, with no local peculiarities worthy of note. In the treatment, the first and most important indication is to prevent the further absorption of septic matter, and to promote the elimination of that which has already accumulated in the system. To the former end, every precaution is taken to secure perfect cleanliness; while for the latter, a solution of the hydrochloric acid and chlorate of potash is administered to the patient during the first week or ten days. To relieve the symptoms that occur during the course of the disease, certain remedies have as a rule yielded better results than any others. To check the diarrhœa during the first few days a combination of calomel, Dover's powder, and nitrate of potash is used, alternating with the acid chlorate solution above mentioned. As the febrile symptoms become more intense this is omitted and some diaphoretic and febrifuge mixture is substituted. During the second week, as the bowels become very lax and tympanitic, nothing has been found to meet the indication so effectually as our "turpentine and laudanum emulsion":—

		Gms. or c.c.
R.	Olei terebinthinæ,	12 00
	Olei gaultheriæ,	2 00
	Tincturæ opii,	16 00
	Pulveris acaciæ,	24 00
	Sacchari albi,	24 00
	Misce et adde	
	Aquæ, q. s. ad	128 00

Sig.—Teaspoonful.

This is given every four hours, alternating with a diaphoretic solution. During all this time, as the patient's temperature runs high, frequent sponge baths are employed to reduce it. There is given the most nutritious food (but not in a solid form), such as wheat flour and milk gruel, and other articles which contain a large proportion of milk. As the appetite is lost this is administered to him regularly, the same as medicine. During the third week, if the vital powers begin to fail, the "turpentine and laudanum emulsion" is alternated with the "strychnia mixture":—

		Gms. or c.c.	
R.	Strychniæ sulphatis,	06	
	Acidi nitrici,	4 00	
	Tincturæ opii,	16 00	
	Aquæ, q. s. ad	125 00	M.

This stimulates the vital functions in the low adynamic stage, until the severity of the fever is past. The use of alcohol in this and similar diseases is deemed of questionable value, reliance rather being placed in good alimentation.

Where complications arise, they are treated according to the indications. The foregoing is the usual course of treatment, but it is promptly varied to meet the requirements of any individual case. One peculiar case was marked by a constant delirium, which continued for several weeks after the primary fever had disappeared. It was probably due to a subacute meningeal complication. After the primary fever had subsided for a week or ten days, a periodic fever of the remittent type was developed, which continued for several weeks longer. During nearly all of this period the delirium was present. The tincture of gelsemium was used alone, for several days, to control the fever. After it had been in use thirty-six hours, the delirium disappeared. Subsequently, by mistake of the nurse, its use was discontinued for forty-eight hours, when the delirium again presented itself, to be once more dispelled by resorting to the use of the gelsemium. The patient was discharged cured. The case suggests the possible anti-deliriant property of gelsemium.

Diphtheria.

This is treated as a general disease, with more or less intense local manifestations. The indications are for supporting measures for the general constitution, with treatment for such local symptoms as may arise. Good alimentation by soft articles of food is directed. The blood poisoning is treated with an antiseptic solution containing the chlorate of potash and hydrochloric acid, which latter also increases the plasticity of the blood. It also, in the act of swallowing it, produces a local astringent and antiseptic effect upon the mucous membrane of the fauces. To this solution the tincture of belladonna is added, because of its known power to produce contraction of the arterioles of the mouth and pharynx, and so possibly lessen the amount of exudation. This is administered in frequent small doses, to obtain its maximum local effect. After the exfoliation of the membranes begins it is discontinued, and a combination of the tincture of iron and chlorate of potash is substituted. When the cervical glands become swollen the following infusion is made:

		Gms. or c.c.	
R.	Aconiti foliarum,	32 00	
	Ammonii chloridi,	16 00	
	Aquæ bullientis,	256 00	M.

Flannel cloths are wet with this hot solution and applied to the neck. This is covered with another dry cloth, so as to retain the heat as long as possible. This has also been very efficacious in relieving acute tonsillitis and other similar inflammations in the cervical region. A stimulating liniment is sometimes used in its stead.

Erysipelas.

Nearly every case furnishes the history either of bad hygienic surroundings or of defective nutrition. In a large proportion of them it was confined to the face. The treatment, quite uniformly, has been twenty-five drops of the tincture of the chloride of iron every four hours, internally, and the carbolized zinc wash locally, with a good wholesome diet. This treatment is most satisfactory.

For periodical methomania, or acute alcoholism, the customary treatment is gram doses each of the chloral hydrate and bromide of potassium every two hours, till sleep occurs. Patients, however, differ in their susceptibility to the action of the drugs. In one case, six grams of each were administered within three hours with no perceptible effect.

Editorial Department.

Periscope.

Remarks on Acupuncture.

Dr. Simeon Snell, L.R.C.P., M.R.C.S., Ophthalmic Surgeon to the Sheffield General Infirmary, writes, in the *Medical Times and Gazette*, July 19, 1880—

Acupuncture, consisting of the introduction of needles in various parts of the body, appears to have been practiced by the Chinese and Japanese from time immemorial, but was only introduced into Europe by a Dutch surgeon about a couple of hundred years since. At the early part of the present century it was a good deal used in England, and among others found a warm advocate in the erudite Dr. Elliotson, so well known as the enthusiastic but misguided supporter of mesmerism and the sisters Key. His article on Acupuncture, in the *Encyclopedia of Practical Surgery*, is, I believe, still the only good one on the subject in our books, and its perusal will well repay those in any way interested in the subject. At the Leeds Infirmary the use of it is almost traditional; it was there I both saw it employed, practiced it myself, and witnessed the remarkable benefits frequently resulting.

The needles generally employed are long, slender, and sharp-pointed, and furnished with a head or small handle of ivory. A large sewing-needle answers the purpose. Care should, however, be taken, to prevent the possibility of its slipping beneath the skin, by placing on it a head of sealing-wax. The needles are generally made of steel, but silver and gold have been used, more particularly in the East. The Japanese are said to be bold in the use of these needles, and plunge them into the various viscera, and even into the fœtus in the womb, to repress its tumultuous movements. Their efficacy was undoubted in maladies, as they said, dependent on the wandering about of winds or vapors.

The operation is performed by pricking the skin and gently pressing the needle onward, in, as some advise, a rotatory manner. The place chosen is the seat of pain. A minute or two will suffice for the needle to remain in the part, though it has been thought better by some for it to be a longer time. Again, only one needle may be plunged into the affected region, or as many as half a dozen. I have seen both a single needle and several needles used, but as I saw no better results in those cases in which a large number were employed, it was always my practice to use a single one.

Now as to the uses of this procedure. The benefit following acupuncture in anasarcous limbs, by allowing the exit of serum, is well known; as are also the capital results often achieved by making numerous punctures in a hydrocele with one of these needles, and permitting the fluid to escape into the areolar tissue, and become absorbed. I have seen benefit from this method in children.

But the cases in which the effects of acupuncture are often so strikingly brilliant are in a different category from these, and the *modus operandi* is not the same. Those I am going to relate will illustrate its use in cases of weakened deltoid from laceration or otherwise following dislocation, or from a fall on the shoulder; another case, its benefit in chronic rheumatism. It has been recommended in rheumatic and neuralgic affections generally. These are the classes of cases I have seen it practiced in, and in most instances with brilliant results. Like every other remedy, it has been put to ridiculous uses, and it was even suggested that the running of a large needle into the right ventricle in cases of asphyxia might be beneficial! But as its employment is attended with but little pain, and as it is but seldom that any ill effects result from it, it is scarcely surprising that enthusiasts should have carried its use to absurd lengths. The employment of the aspirator in tapping a distended bladder, and its other uses, have additionally proved the little harm resulting from the insertion of a small, clean needle into different parts of the body. It is worthy of note, however, that, while the Japanese plunged these needles into the abdomen and other important regions of the body, it would appear that they always avoided the neighborhood of joints.

He then relates a number of cases, but we have here only space for one:—

Case 1.—T. G., aged thirty-five, on January 23d, 1872, stated that a week previously he had

fallen, striking his hand and arm. He also said "his hand was now all right, but he could not move his shoulder much." He was able to lift the elbow from his side, but only slightly to raise it, and could reach the hand across the front of his chest, but only a little distance behind his back. Putting his arm backward he could only reach the upper part of his neck with the hand. One acupuncture needle was introduced through the deltoid, toward the outer side and rather above its insertion, followed by marked improvement. He now fixed the pain more to the inner side of the deltoid, so the needle was introduced again, the man exclaiming, "That is the place!" In a very few minutes he could raise the arm up quite straight, touch the top of his head easily, and in fact move it just as well as the other.

Remarkable Phenomena Observed after Severe Injury to the Brain.

L. A. Glaze, M.D., Gainesville, Ky., reports the following case in the Nashville *Journal of Medicine and Surgery*, for August, 1880:—

On April 30th, J. C. M., who was engaged in sawing walnut lumber, passed into the pitment directly beneath the revolving saw, to get a spade, and on rising from his stooped posture his head came in contact with the saw above, which traced the coronal suture, dividing the frontal and parietal bones, passing on through the temporal regions on the left side, throwing the brain substance to a considerable distance, spattered upon the timbers above.

I was immediately summoned, and on arriving at the place I found the subject lying upon the floor in a pool of blood and brain matter, apparently lifeless, with mourning friends and relatives bowed around him. Upon examination I found the pulse still beating and indications of reaction; of course I pronounced him not yet dead. With a little tepid water I syringed out the wound, and having thus cleared out the track of the saw, I carefully removed all spicula of bone found detached and debris of soft tissues destroyed in the track of the wound. Owing to considerable hemorrhage and depreciation of vital powers I suspended further treatment, leaving unsmoothed the jagged edges of bone around the wound. I left him with 2½ drachms of bromide and 30 grains of hydrate of chloral to be taken every two hours alternately through the night. To my astonishment on the following morning, upon examination, I found him with a good strong pulse, speaking rationally and in the brightest hopes of his recovery. I immediately sent for counsel, Dr. Jones, who skillfully, by delicate procedure, succeeded in smoothing some portions of the jagged edges of bone, when, apprised of the great loss of blood and the threatening secondary hemorrhage, we proceeded no further.

On Sunday morning I saw him again, in company with Dr. Jones; we found him apparently in the same condition as on the evening before, rational, with no additional symptoms.

We then sent for Dr. Porter, of Bowling Green, whose skill and experience is worthy of note.

On Monday, fourth day after accident, in the evening, he fell into a quite peaceful slumber. In two hours and a half he woke, called for water; I questioned him as regarded his symptoms; he conversed rationally at the time, observed he felt better and much refreshed. Soon he passed into a quiet and unconscious state, from which he never spoke again; the right side became paralyzed, breathing became stertorous, and on Wednesday evening, the sixth day from accident, he died, without a struggle.

Is it not a psychological problem yet unsolved, that on questioning him as regarded his condition, he always spoke rationally concerning his symptoms, recognized faces, conversed rationally upon all subjects with which he was familiar before the accident, and yet manifested a total loss of memory concerning all events transpiring after the accident?

An Ethnological Phenomenon.

The Independent Practitioner, for August, 1880, contains the following interesting communication from Harvey L. Byrd, A.M., M.D.:—

So constant and unvarying have been the appearance of a dark or blackened condition of the genitalia, in infants of mixed Caucasian and Negro blood, in an experience of more than thirty years, that I am led to believe it of universal occurrence; so long, at least, as a trace of negro blood continues to be mingled with that of the white progenitor in its future epigone.

In the hybrid, mulatto, the scrotum of the male will be found dark, or black, and the vulva of the female child will be of the same color. Thus, in the offspring of a white male and negro female the scrotum will be found dark as the mother, while the remainder of the body will be of the mulatto hue, or a commingling of the white and black color of its parents; and where the sex of the offspring of such parents is female, the dark color of the mother will be found to cover the vulva, and the usual mulatto complexion all other portions of its person. This darkness of the genitalia is found also in the offspring of the mulatto woman and white man, and in the children of a quadroon by a Caucasian father, and even in those of the octoroon sired or begotten by a white man. How much further it is transmitted I have had no opportunity of knowing; but thus far it is well defined, and unmistakable, in the two latter removes, even where the skin and all the usual characteristics of the highest blonde type are prominent and distinguishable. After discovering it for the first time in an infant mulatto, my observations were continued with all the care attainable, under various circumstances; in the newly-born, the young, the middle aged, and in the cases each of an aged mulatto man and woman. The discoloration seems, therefore, to be prominent, as well as constant, in the mixed blooded descendants of the white and black races. Whether the offspring of Caucasian women and negro men present the same peculiarity I have had no means of ascertaining; as, happily for our race, such cases of miscegenation and degradation, of Caucasian (white) women, in this country, are of exceedingly rare occurrence. Inquiry among intelligent negro midwives in

some of our Southern cities confirms my own observation of this phenomenon in every particular. How much a knowledge of this ethnological fact, for fact it is, may be of value in medico-legal science and future race investigation, can only be left to conjecture; but that it will be found a factor of value in each, can hardly admit of reasonable doubt even now.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——"Contributions to Gynæcology," No. x, reprinted from the Annals of the Anatomical and Surgical Society, Brooklyn, Vol. II, 1880, contains the reports of a case of fibro-sarcomatous tumor of the uterus, operation, recovery, and also a case of cancer of the rectum, excision, recovery, by John Byrne, M.D., M.R.C.S.E.

——Parts 11 and 12 of Dr. George Henry Fox's series of "Photographic Illustrations of Skin Diseases," published by E. B. Treat, No. 805 Broadway, New York, contain the following beautiful illustrations, with accompanying descriptions: Herpes facialis; hydroa bullosum; erythema circinatum and erythema exfoliatum; purpura simplex; cornua cutanea; alopecia areata; morphæa; scleroderma; sarcoma pigmentosum. This series is soon to be followed by another, entitled "Photographic Illustrations of Cutaneous Syphilis."

——The tenth of the series of American Health Primers, edited by W. W. Keen, M.D., is on the "Skin, in Health and Disease," by L. Duncan Bulkley, M.D. It is divided into six chapters: Chapter I treating of "The Anatomy and Physiology of the Skin;" Chapter II is on "The Care of the Skin in Health;" Chapter III, on "Diseases of the Skin," and Chapter IV, on "Diet and Hygiene in Diseases of the Skin." A very complete index is appended. Published by Presley Blakiston, 1012 Walnut street, Philadelphia. Price 50c.

BOOK NOTICES.

Naso-Pharyngeal Catarrh. By Martin F. Coomes, M.D., Professor of Physiology, Ophthalmology and Otology, in the Kentucky School of Medicine, etc. Louisville, Ky., Bradley & Gilbert, publishers, 1880. Cloth, 8vo, pp. 165. Price $2.

After a few pages devoted to the anatomy and histology of the parts under consideration, the author proceeds to give clear and minute instructions how to examine the pharynx and nasal cavity, rendering the subject more easy of comprehension by the introduction of several illustrations, showing the instruments needed and the methods of using them. He then gives a brief review of the remedial agents, both local and constitutional, including climate, which he has found most useful. We are somewhat surprised to find that he makes no mention of iodoform, a remedy which of late has gained considerable reputation, and which we have found of great utility in the treatment of ozæna. The subject of catarrh, acute and chronic, with its various complications, is next taken up and discussed with thoroughness, and a large number of cases are recorded. The final chapter treats of catarrhal and purulent inflammations of the drum cavity. The entire subject is handled with remarkable clearness, and the work will prove useful both to the student and practitioner.

Medical Education and Practice in All Parts of the World; by Herbert Junius Hardwicke, M.D., Member of the Royal College of Physicians, and Fellow of the Royal College of Surgeons, Edinburgh; Physician to the Sheffield Public Hospital for Diseases of the Skin; Author of "A Guide to European Universities," etc., etc. Presley Blakiston, 1012 Walnut street, Philadelphia, 1880. Cloth, 8vo, pp. 209. Price $3.00

At the present time, when the subject of medical reform and a higher standard of medical education is occupying the minds of most of the medical men in this country, a work like the one before us cannot but prove of the highest value, as it will enable any one to compare the laws which govern the practice of medicine in every country, and the requirements for graduation at every university and medical school throughout the world. With regard to the United States the author seems to be somewhat prejudiced. He says that "until lately the condition of medicine was very bad indeed; universities were established all over the country, and degrees sold in open day with the coolest effrontery;" in proof of which, he quotes the "Exposure of Dean Miller's 'Doctor' Factory," in the Philadelphia *Record*, February 28th, 1880. He, however, acknowledges that we have a few respectable institutions. The compilation of this work appears to have been done with great care, and the information it contains may on the whole be considered reliable, and we trust that the author may be amply rewarded for the vast amount of labor and the valuable time he has expended on its preparation.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

PROTECTION FROM VENEREAL DISEASE.

At the session of the American Public Health Association which convened at Nashville last November, a motion was unanimously adopted, that the President appoint a committee of three who should consider the suggestions or substance of an address delivered by Dr. A. L. Gihon, Medical Director, United States Navy, and report at the next meeting resolutions looking to the establishing of a plan for protection from venereal diseases, and also that Dr. Gihon be chairman of that committee.

Dr. Gihon's address was eloquent and pointed, and we shall be surprised if this committee, like one on the same subject appointed by the American Medical Association some years ago, is scared into silence by the clamor of clergymen, women, and narrow sectarians.

The most irrefragable evidence is yearly increasing that such a plan as that adopted by England for garrison towns could be profitably modified and extended to all dense centres of population. The experiences of all the leading European States have convinced the medical and sanitary authorities that the laws for the control of prostitution, the periodical examination of women, and the prohibition of street walking are beneficent, and should not be repealed. But we could do much good with a few simple measures, without imitating these forms of legislation. As Dr. Gihon remarked, there is no need to wound any one's sensibilities by an elaborate system such as the French, Italian, Portuguese or German, based upon the official recognition and organization of prostitution. "In Denmark and Norway," says Surgeon Thomas C. Walton, United States Navy, "while prostitution is looked upon as an ineradicable evil, yet by the mere application of the ordinary laws relating to disorderly characters and those for the suppression of contagious diseases, through the energetic action of the sanitary board, this vice and its consequences are probably held under better control than in any other part of Europe."

No doubt similar laws would have equally good results in this country, and one would suppose that in view of their universal adoption by most of the civilized nations of the day, we might reasonably expect their prompt introduction into the United States. But a singular fact presents itself. Although in Great Britain the medical press is unanimous and outspoken as to the advantage of such legislation, and constantly press for its wider adoption, in the United States the medical press is either silent on the subject or is adverse to restrictive measures. The reasons for this difference in the position of the medical press in the two countries are the general ignorance on the exact nature of the laws in question, a fear that religious prejudice may be aroused, and a blind bias against "licensing vice," as it is called.

Within a year, a medical journal which should have known better asserted that it would not be possible to extend the British Contagious Diseases Acts to civil life. In striking refutation of this, and in apt proof of the ignorance of the subject which prompted the objection, Dr. A. Bernard, of Liverpool, read an article before the

last meeting of the British Medical Association, giving reasons why these acts ought at once to be extended to all seaports. He arranged his remarks under the following headings: 1. The prevalence of venereal, especially syphilitic, disease in seaports where the Acts were not in force among seamen and prostitutes; 2. The deficiency of hospital accommodation for women suffering from these diseases in ports not under the Acts, contrasted with the ample provision made by Government for their reception in ports where the Acts are in force; 3. The great reduction of disease in ports under the Acts, as shown by several Parliamentary papers; 4. The great benefit of these Acts in diminishing prostitution, exterminating juvenile prostitution, and their moral and social benefits, as testified by clergymen and ministers. A Parliamentary paper, containing replies given by the Rev. E. H. Wilkinson, vicar of Portsmouth, to questions addressed to him by Convocation, was distributed among the audience, and testified to the value of the Acts. A letter from the Rev. D. Webster, of Cork, was also read, in which the Acts were described as one of the greatest blessings ever conferred on Great Britain. It was also shown that the Acts had been of incalculable benefit in reclaiming fallen women, restoring them to their friends, and in deterring others from commencing an immoral life.

One would suppose that the editor whose strictures we refer to must have felt convicted of his ignorance when his eye met Dr. Bernard's article.

It is to the medical profession alone that the public can look to take action in this matter. With the evils of venereal disease becoming more and more apparent, with the unchecked advance of prostitution in all our large cities, and with the examples of other nations before us, it is strange indeed that we continue so indifferent to the magnitude and pressing danger of this evil in our national home.

—The *British Medical Journal* informs us that there was only one death from smallpox in Copenhagen during the year 1879. Compulsory vaccination is most rigidly enforced in Denmark.

Notes and Comments.

Therapeutical Notes.

THE USE OF BELLADONNA IN THREATENED ABORTION AND IN DYSENTERY.

Dr. Q. C. Smith, of Austin, Texas, writes, in the Nashville *Journal of Medicine and Surgery*, for August, 1880—

When a miscarriage is threatened, give fl. ext. belladonna, two to five drops every thirty to sixty minutes, until pains are relieved. Should disagreeable effects follow the use of belladonna, alcoholic stimulants will relieve them. We have given belladonna in quite a number of instances, until the patient was delirious, but never observed any permanent bad effects follow such heroic use of the remedy; but, on the other hand, noted unlooked-for good results follow such treatment. Belladonna has long been our favorite remedy for acute dysentery. We often use it as follows: dose for adults:—

℞. Fl. ext belladonnæ, ℥j
Subnit. bismuthi, ʒij
Elix. cinchonæ, ʒij. M.
Ft. sol.

Sig.—Teaspoonful every half hour until pains are relieved. Shake the bottle before each dose.

Also give sulph. magnesia, teaspoonful in little water every hour, until free watery discharges are produced. Keep the patient quiet in bed twenty-four hours after the salts cease to operate, and the case is cured without further drugs, unless a mild tonic is indicated.

Or the following:—

℞. Fl. ext. cinchonæ, ℥j
Fl. ext. belladonnæ, ʒij
Codeiæ, gr. xx
Syr. tolu, ʒj. M.
Ft. sol.

Sig.—Teaspoonful every half to one hour, until pains are easy; then smaller doses at longer intervals for a few hours.

At the same time give sulphate magnesia, level teaspoonful every hour, until bowels move freely, then in smaller doses, at longer intervals, for several hours. This will cure almost all cases of acute dysentery within a few hours. The patient should remain quiet in bed twenty-four to forty-eight hours.

FORMULA IN CHLOROSIS.

For nervous and hysterical women with impoverished blood, Dr. Siredy recommends, in *l'Union Méd.*, June 8th, 1880, the following mixture: Citrate of iron, 5; bromide of potassium, 10 to 12; and Malaga wine, 250 parts,

by weight. A tablespoonful to be taken at the commencement of the two principal meals.

Traumatic Tetanus Successfully Treated by Chloroform Inhalation.

Mr. Frederick A. Gray relates, in the *Lancet*, July 31st, 1880, the case of a boy, aged ten years, who two weeks previously had the middle finger of his left hand crushed in a turnip cutter. He complained of some stiffness and pain of the jaws, and afterward of pain and stiffness in his back and severe pain in the pit of his stomach, which was of an intermittent character. These pains got worse and more frequent up to the time of his admission.

On admission, March 29th, the middle finger of the left hand was in a very unhealthy condition, the soft parts sloughy, and the bones comminuted up to the second joint, the end of the finger hanging by tendons, and gangrenous. The jaws were almost fixed, and the teeth could not be separated more than a quarter of an inch. Fluids could be swallowed with great difficulty, any attempt producing severe spasm. Opisthotonos well marked, returning every two or three minutes, when pain in the epigastrium was most severe, and the muscles of the abdomen became hard as a board with each recurrence of the spasm. The facial muscles were affected also, and the "risus sardonicus" was well marked. The spasms were most severe, causing the patient to be jerked up in the bed, bent back, with teeth clenched and breathing suspended, till he seemed in imminent danger of suffocation, his complexion assuming an almost black hue at times.

Having been placed under chloroform, the mutilated finger was amputated at the metacarpal joint. During the time he was under chloroform there were no spasms, but they soon began to return on the effects passing off. Hydrate of chloral and bromide of potassium ordered, ten grains of each; this at first relieved the spasm, but soon lost its effect, though the dose was increased.

March 30th. Determined to keep him under the influence of chloroform, and chloroform inhalation was substituted. This had the effect of preventing spasms altogether if thoroughly under its influence, and he would remain almost free for a couple of hours after, when the inhalation would have to be commenced again. Strong beef tea and milk were given at regular intervals, when he was allowed to come from under the influence of the anæsthetic. The bowels, which were very costive, were kept open by castor-oil enemata. These proceedings were continued up to the 6th of April, during which time the spasms maintained the same intensity and frequency when the influence of the chloroform was removed. After this the spasms began to abate, and in a few days gave place to twitchings. The chloroform was gradually lessened and then discontinued. The twitchings continued for some days, and were perhaps kept up by some ascarides, of which a dose of santonin relieved him. The wound had in the meantime healed almost by first intention, and the boy was discharged, apparently none the worse for his dangerous illness, on the 15th of April. The total quantity of chloroform inhaled was three pounds.

Tuberculosis as an Infectious Disease.

Dr. L. G. Bryhn relates, in *Worsk Magazin for Lägevidenskaben*, some cases in proof of the infectious character of pulmonary tuberculosis, of which he has become convinced by observations made during a practice of thirty years' duration. A phthisical man married a woman of healthy family; the man died, the woman became phthisical, as did also her sister, who resided in the house during the man's illness. The latter married a man of great strength, of sound family; he, too, was attacked, and also his sister's daughter, who resided some time in the house. One of their children died of tubercular meningitis, two had signs of pulmonary tubercle, one was free. The girl who served the first man's wife became tuberculous, went home, and died. Her sister was infected by her; both their parents had lived to a great age, and tuberculosis had never before shown itself in the family.

Ergotine, its Inconveniences and its Dangers.

Dr. Boissarie, in a communication read before the Académie de Médecine, and published in the *Gazette Médicale de Paris*, deducts the following conclusions: "Ergotine, which renders important services in hemorrhages when we have need of immediate action, cannot be administered with impunity in affections of long duration, in order to affect the system. Ergotine has the property of accumulating, remaining in the system, and indicating its presence at a period more or less distant by some sudden serious manifestation. Following the teaching of Trousseau, of giving for a long time small doses of the poison, is to expose the patient to the risk of sudden gangrene."

Correction, by Means of Glasses, of the Ametropia of Keratoconus.

The subject of the treatment of conical cornea by neutralizing the abnormal curvature with properly ground glasses was, according to the Edinburgh *Medical Journal* for June, 1880, introduced by Rælmann at the last Ophthalmological Congress at Heidelberg. From measurement of the curvature in five cases he found that the surface of the cornea in keratoconus, instead of being spherical, more nearly represents a hyperboloid. He therefore had conical glasses ground, and tested their effect in these cases. Unfortunately, four of the cases presented complications (opacity of the cornea and vitreous, detachment of retina), consequently much improvement could not be expected in them, although the improvement of vision produced by the new glasses was greater than could be attained by the combination of concave glasses with a stenopaic aperture. The fifth case was that of a girl aged nineteen, with typical keratoconus of the right eye and perfect transparence of the cornea. Without any glass, V=fingers at 15′; with stenopaic aperture concave and cylindrical glasses, V=$\frac{1}{10}$; with the conical glasses, V=$\frac{1}{2}$. Without correction of any kind, and with concave glasses, she was able to make out with difficulty Jæger 9 and 10; with conical glasses she read Jæger 3 and 4 at a comfortable distance, and Jæger 1 and 2 close up to her eyes. These glasses were found to be by no means easily ground, as the grinding block must be made to rotate on its axis alone. A hyperbolic grinding surface would soon lose its shape; Rælmann used, therefore, the asymptotic cone to the surface required.

Acute Rheumatism Treated by Hot Washing-Soda Baths.

In the *Australian Medical Journal*, for April, two cases of acute rheumatism treated by hot washing-soda baths are reported by Mr. Bingham Crowther, L.R.C.P., as occurring under the care of Dr. E. L. Crowther. In this treatment the patients are taken in a blanket by the four corners, and lowered down in a recumbent position into the bath. Half a pound of common washing-soda is added to the water, as hot as can be comfortably borne, the patient remaining in from ten to fifteen minutes, then lifted into a dry, warm blanket, and replaced in bed. According to the reporter, profuse diaphoretic action follows, along with diuresis, to the immediate relief of the sufferer, pains rapidly depart, and sleep follows the use of the remedy. In one severe case convalescence was effected in eleven days. The other case was treated without permanent benefit with salicylate of soda and various sedatives and salines. On the 25th of December, 1879, "the patient becoming immovably fixed in bed by the affection of new joints, and all remedies proving useless, the washing-soda bath was tried as a last chance. After remaining in ten minutes he was removed. His complexion soon changed from a muddy to a natural color, and the pains left the joints." On the 27th there remained only a little aching in the body and slight pain in the left wrist. Complete recovery having been established on the 8th of January, the baths were discontinued.

The Treatment of Scleritis.

Galezowski, in *Recueil d' Ophthalmologie*, for May, 1880, considers it of great importance to distinguish between scleritis and sclero-keratitis. When the inflammation begins at some distance from the cornea, it is seldom complicated with iritis, and though often rebellious, disappears in the long run without leaving any trace. If the inflammation of the sclerotic begin near the cornea, serious complications in the shape of iritis and keratitis are apt to ensue, and necessitate surgical interference to prevent more or less complete blindness. For the first form Galezowski uses alternate instillations of atropine and eserine, blisters to the temples, steam douches to the eyes, and, internally, salicylate of soda if of rheumatic, and iodide of potassium if of syphilitic origin. Atropine alone induces the complication of paralysis of accommodation, which is generally more disagreeable for the patient than the slight inconvenience caused by the scleritis itself. This is avoided by using atropine in the evening and eserine in the morning. In obstinate cases, scarifications at intervals of ten days are often useful. For sclero-keratitis, iridectomy is, according to Galezowski, little short of a specific.

Bony Tumor in Muscle.

In the *Press Méd. Belge*, Dr. Thiriar relates the case of a sawyer, thirty-six years old, whose foot slipped while playing at skittles, he at the time having in his hand a bowl weighing between twenty and thirty kilos. He felt a violent pain opposite the insertion of the adductor longus in the pubis. Next day he felt in this locality a tumor the size of a pea, which gradually enlarged in all directions. At first it caused neither pain nor inconvenience; but after a while pains came on, and motion became first difficult and then impossible. When Dr. Thiriar first saw the pa-

tient, some weeks after the accident, he found a hard conical tumor, five centimetres in length, extending from the pubis into the adductor. Its removal was accomplished between two and three months after the accident, the adhesion to the pubis being so strong as to require the use of a forceps. It was found to be a true osteoma, composed of spongy bony tissue. It was supposed to have originated in the portion of the adductor attached to the pubis, and gradually invaded the muscular tissue. Recovery from the operation was complete three months after the occurrence of the accident.

The Non-Conductivity of Fat.

Dr. E. S. Boland, of Boston, states, in the Cincinnati *Lancet and Clinic*, July 24th, 1880, that he has recently had a case illustrating in a remarkable degree the non-conductivity of fat. While making an autopsy on a stout, very obese woman, who died at the end of a week of acute mania, he found the portal temperature 110.5° F. She had then been dead two hours and fifteen minutes, had been washed and laid out, and had an ice tank on her chest and abdomen for fifteen minutes prior to commencing the autopsy.

Her axillary temperature, taken carefully twenty minutes before death, was 107.5° F. The physiological temperature of the blood in the portal vein is put down at 107°, when the surface heat is 98½° or 99°, so that the difference here was not abnormal. And it is abundantly seconded that pro-agonic elevations sometimes reach a very high degree. The interesting feature connected with this case is the persistence of the interior heat after bathing, ice application, etc.

Correspondence.

Gangrene of Scrotum and Penis.

Ee. Med. and Surg. Reporter.

I was called, October 27th, 1878, to see M. H., a colored man, aged about 30. Patient had recently been on a spree, and slept in the gutter one night; the scrotum was swollen the next morning, and he went home and applied alum wash, and resorted to various domestic remedies, but the swelling steadily increased, and at the end of a week I was called.

Patient had an old stricture of the urethra, of several years' standing, which he had neglected to have cured. There was probably rupture of the urethra posterior to the stricture, and extravasation of urine into the cellular tissue of the scrotum and penis, but he stated that there had been no particular trouble in urinating recently, and that there was no trouble at the present time.

The pulse was 90 and soft and compressible; the tongue heavily coated, and the patient very much exhausted. On examining the parts, found the scrotum fully as large as a man's head, of a doughy feel and an ashen hue; the penis was also enormously swollen and the skin gangrenous. Made four large, deep cuts in the scrotum, and a large quantity of clear, amber-colored fluid drained away. This was probably urine. The scrotum was then very much reduced in size. Gave 1 gr. doses of quinia, and applied a five per cent. solution of carbolic acid to the parts.

October 28th, pulse 80, distinct line of demarkation between the dead and living tissues. No trouble in urinating. The slough came away on November 3d. The scrotum sloughed completely away, leaving the testicles bare, except their covering with the tunica vaginalis. They were held in position and drawn up snugly by the cords, but were exposed in their full extent. The skin sloughed from the penis from near the pubes to the corona glandis. The parts were well washed twice a day with the carbolic solution, and carbolized cosmoline applied on cloth.

Granulation sprang up from the surface of the tunica vaginalis, and from the edge of the skin, and the skin gradually encroached upon and finally covered the testicles, the opposite edges healing together.

This process of healing occupied about four months. After it was healed, matter formed and was let out, after which it again healed and remained sound. The penis was the last to recover entirely, but healed with a hard cicatrix, which does not interfere with the functions of the organ.

E. G. Carpenter, M.D.

East Greenwich, R. I.

A Case of Carcinoma of the Liver, with Post-Mortem Examination.

Ed. Med. and Surg. Reporter:

The ante-mortem history of this case is as follows:—

Mr. J. H. S., of Lyons, Pa., a retired gentleman, aged fifty-three years, had, sixteen years ago, a cancerous formation about the right knee joint, which finally required an amputation. The operation was successfully performed by Henry Smith, M.D. For the next fifteen years he simply complained of indigestion at short intervals.

February 12th, 1880, he applied to Dr. F. K. Spang for treatment, when he complained of obstinate constipation and considerable flatus. An examination showed a somewhat enlarged liver, though not prominently diagnostic. The Doctor prescribed a laxative and Fowler's solution as an alterative. He, however, grew worse, having obstinate vomiting and cold sweats, with slight dyspnœa. His pain was never severe, but the disease assumed a more distinct form daily, and symptoms became more general. There was, however, a decided change in the case April 15th, 1880, when a paralysis of the right upper extremity occurred, and Dr. Shoemaker, of Kutztown, was called in consultation. At this time the swelling in the right hypochondriac region increased considerably, and during the next weeks

there was a constant increase noticeable. The treatment, now, was mostly palliative, with tonics and alteratives, and maranta as a nutrient. As the case became more advanced, the diagnosis was carcinoma. He lingered in a somewhat comatose condition for the last two weeks, and could not speak beyond a whisper. The last two days he would not take any nourishment whatever, and now the whole abdominal region became enormously distended. His death took place June 5th.

The post-mortem of the case revealed a carcinoma of a pure colloid form, and medullary, growing from the central portion of the liver, between the quadrate and spigelien lobes, pushing up the diaphragm to the third costal interspace, and extending down to within seven centimetres of the pubic bone, rendering a complete displacement of the whole viscera. The jejunum and ileum were found completely pressed into the left iliac fossa, and the cardiac portion of the stomach was perpendicular to the pyloric portion, with the duodenum encircling the organ. The transverse colon was stretched across the hypogastric region, from the right to the left inguinal. The extension of the growth upward into the pleural cavity on the right side caused complete atrophy of the right lung. The whole mass of growth by weight showed eleven kilogrammes (about twenty-two pounds.) The most peculiar circumstance in the course of the examination was a portion of the left lobe, about nine centimetres square, attached to this immense carcinomatous growth, which was perfectly normal, and under the microscope revealed to us no cancer cells. There have been numerous theories advanced as to this occurrence. Rindfleisch does not specially give any account of such development; he says "that the whole of the organ is affected through the division of the portal circulation; that there is a cancerous embolism; first a thrombosis of the portal vein, and then a transformation of the thrombus in the ramifications of the vein. According to this all portions of the organ would be affected equally. However, here we have the anomaly; and as this is a most interesting case, it may be of extreme importance to those who are at present investigating carcinomatous growths.

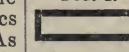
H. Herbert Herbst, A.B.,
Trexlertown, Pa. *Stud. Med.*

An Improvement in the Trephine, and a New Mode of Operating it.

Ed. Med. and Surg. Reporter.

In August, 1879 when about to operate for a case of obstinate neuralgia of the inferior dental nerve, it occurred to me to use the dental engine for the purpose of perforating the bone, the ordinary trephine being too clumsy in this case. I applied to my friend, Dr. D. T. Pepper, dentist, who kindly assisted me in the operation.

Placing the patient under the influence of ether, and drawing the lips backward and downward, I made a free incision, exposing the bone at the spot on which I wished to operate. Then, with a small circular saw, such as is used by dentists, I made a series of cuts, in the manner

Fig. 1.  indicated in Fig. 1, and removed the piece of bone between the cuts with a small chisel. I then excised about half an inch of the nerve.

Perfect relief was afterward experienced by the patient, who had suffered for a number of years the most intense agony, and had gone the rounds of the hospitals and college clinics without the slightest benefit.

The necessity of having a more suitable instrument to perforate the bone led me (with the assistance of my friend, Dr. Pepper) to have a small trephine constructed for use with the dental engine.

Fig. 2.

The cut, Fig. 2, represents the instrument, and will explain itself. It can be used in any operation requiring the trephine, in any part of the body. It cuts quickly, cleanly and neatly. Its superiority over the old method will at once be obvious to any one.

William C. Todd, M.D.
Manayunk, Philadelphia, Pa.

The Diploma Traffic.

Ed. Med. and Surg. Reporter.

In the last issue (July 31st, 1880), of the Medical and Surgical Reporter, I noticed an able article on the Diploma Traffic, with trite remarks and comments, from the pen of Dr. J. P. Dake, of Nashville, Tennessee, with which I was very favorably impressed. I have long been satisfied that this is a subject that County Medical Societies should not be expected to deal with at all, for the very reason that the non-professional public would at once accuse the honorable members of our Medical Societies and Associations of making war with bogus Doctors from motives of professional jealousy.

Furthermore, how can we expect the general public to be able to discriminate between duly qualified members of the profession and the medical tramp, since the latter are generally abundantly supplied with the *gift of gab* and a "*suaviter in modo*" that would naturally impress strangers very much in their favor. We have in this section of the country a large number of "quasi doctors" who entered upon the arena of life as preachers, tailors, shoemakers, machinists, etc., and in the course of a short time (comparatively), have given up their legitimate professions and avocations for what they considered a more honorable and lucrative one, and like meteors have suddenly blazed out upon the world with a comet-like tail of M.D. attached to their names.

As the doctor has wisely intimated, we can see no other way of eradicating this evil than by legislative enactment in the way that he suggests. Were all members of our profession required by law to register their diplomas at the County Clerk's office in each of their respective counties, when they entered upon the practice of their profession, then the public would have an available

means of discriminating between those who are and who are not qualified as medical practitioners. I have no doubt but what there are many others beside myself who would be very much in favor of this system, and would cheerfully and willingly pay the registration fee for enjoying that privilege.

Let us hear from some other members on this subject. A. O. STIMPSON, M.D., C.M.

Thompson, Pa., August 14th, 1880.

NEWS AND MISCELLANY.

Purification of Sewage.

The city of Paris, says the *British Medical Journal*, has practically tested various chemical and other means of dealing with its sewage, and is now irrigating about a thousand acres of land within five miles of the Tuileries. It is, therefore, interesting to find that on June 23d last the Municipal Council of Paris resolved, among other things, "To approve, firstly, the continuation of irrigation in the fields of Gennevilliers, and the carrying of the sewage to the lower northwestern part of the peninsula of St. Germain and adjoining farms, and the delivery of sewage from the conduits to persons on their routes who shall be willing, by agricultural, chemical, or other means, to cleanse it at their own expense and risk, for the sake of what they may be able to get out of it, subject to rules to be prepared; secondly, to ask the Government, in case the 1500 *hectares* (3700 acres) should be insufficient for the purification of the sewage without annoyance to the neighborhood, to take into immediate consideration the extension of the present proposal and the irrigation of other districts in the valley of the Seine."

Professor Nussbaum's Jubilee.

The jubilee of the renowned surgeon, Professor Nussbaum, has, according to the *Medical Times and Gazette*, July 31st, 1880, been recently celebrated at Munich, on the occasion of the twenty-fifth year of his doctorate. The Municipality of Munich presented him with a diploma, in which it is said, "Not only in peace, but in war, have you devoted all your strength to the service of fatherland and of mankind, and your renown has extended far beyond the limits of our country. But we owe our especial acknowledgments to you for the vast and unpaid services you have performed during two decades as chief medical officer of our hospital, and especially the beneficial introduction of the Listerian method in its correct mode of application. Our special thanks are due to you for having devoted your science and knowledge with equal consideration and love for the poor as well as for the rich."

Women to be Excluded from the International Medical Congress.

The *Lancet*, July 31st, informs us that the necessary arrangements in preparation for the seventh session of the International Medical Congress, to be held in London in August, 1881, are progressing. The committee have discussed the question of the admission of women to the meetings of the Congress, and by a decided majority have determined to issue invitations to male practitioners only.

OBITUARY NOTICES.

—Dr. Horace B. Milbet, 60 years of age, died recently, at Buffalo. He was a prominent member of the Wyoming Medical Society, and was formerly paymaster of the Onondaga tribe of Indians.

QUERIES AND REPLIES.

Dr. J. A., of Vt.—The formula for curaçoa is as follows:—

℞. Bitter orange peel, 250 grams or about ʒviij
Cloves,
Cinnamon, of each 4 grams or ʒj
Brandy, 5 litres, or about Ox

Macerate for eight days and add—

Distilled water, 500 grams or about Oj
White sugar, 1250 grams or about ʒxlij.

Dissolve and filter.

DOSE.—Half an ounce to an ounce, after meals.

The medical properties of this—in some parts of Europe—fashionable beverage would be about the same as that of any other aromatic tincture, but it is much more dangerous, on account of its pleasant taste.

We will mail you the book you inquire about on receipt of $1.25.

MARRIAGES.

CATE—IRVING.—At Litchfield, Conn., August 2d, by the Rev. Storrs Seymour, Hamilton J. Cate, M.D., and Miss Mary S. Irving, daughter of the Rev. Theodore Irving, LL.D., of New York.

CRANE—KITTENGER.—July 20th, at the Methodist Episcopal Church in Lyndonville, N. Y., by the Rev. J. E. Bills, Dr. Lucien D. Crane, of Akron, N. Y., and Theresa U. Kittenger, daughter of the Rev. G. W. Kittenger, pastor of the above-named Church.

DOREMUS—WARD.—At Washington, D. C., Aug. 4th, by the Rev. Dr. Lindsay, Dr. Charles Avery Doremus, of New York, and Bessie J., daughter of the late George W. Ward, of New Orleans, La.

JONES—GILMAN.—In East Lempster, Vt., July 8th, by Rev. J. Hooper, Fred P. Jones, M.D., of Goshen, and Sullivan A. Gilman, of Unity.

LEE—SNOW.—In Auburn, N. Y., August 5th, 1880, at the First Universalist Church, by the Rev. Charles Follen Lee, of Boston, assisted by the Rev. T. E. St. John, Dr. Frederick H. Lee, of New York, and Florence, eldest daughter of B. B. Snow, Esq., of Auburn.

WHEELER—FENTON.—In Brattleboro, Vt., July 27th, by Rev. Henry Lane, Dr. C. S. Wheeler, and Katie A. Fenton.

DEATHS.

BURDSAL.—In Cincinnati, Ohio, Saturday, July 31st, 1880, at 11 o'clock, A.M., Dr. Laurens A. Burdsal, aged 31 years.

HEBERTON.—At Mt. Desert, Me., July 25th, Dr. G. Craig Heberton, of Philadelphia, in his fifty-eighth year.

LEE.—On July 28th, 188⁰, in the borough of West Chester, Pa., Dr. William F. Lee.

MEGARGEE.—In this city, on July 30th, 1880, Dr. Calhoun Megargee, son of the late Samuel Megargee, in his 27th year.

WILSON.—In this city, suddenly, on the 4th instant, Dr. J. F. Wilson, in the fifty-sixth year of his age.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1226.] PHILADELPHIA, AUGUST 28, 1880. [Vol. XLIII.—No. 9.

Original Department.

Lecture.

VII. PULMONARY PHTHISIS.

Delivered at the Philadelphia Hospital, December 31st, 1879,

BY WM. PEPPER, M.D.,

One of the Physicians to the Hospital, and Professor of Clinical Medicine in the University of Pennsylvania.

REPORTED BY WM. H. MORRISON, M.D.

Gentlemen:—I shall not, to-day, bring any cases before you; but having cleared the way by the discussion, last week, of the treatment of the great complications of phthisis, night-sweats, fever, hemorrhage, diarrhœa, and laryngitis, I shall now pass to the treatment of the general condition. In the first place, if it is true in regard to any disease at all, that we are not to treat the disease as a separate entity, but to treat the sick person as an individual, it is more true in phthisis than in any other. In its treatment we are to begin before the phthisis has commenced, since the treatment of phthisis is to prevent its development. This applies not only to cases in which there is a local disease of the lung; but still more does it apply to persons who are evidently getting ready to have phthisis. Where we have an individual showing a weak constitution, who has little power of maintaining his temperature and circulation, who loses flesh upon slight provocation, who, after an acute illness, recovers slowly, such a person is predisposed, upon any attack of lung trouble, to have it pass into a chronic state. Where we see these indications of weakness of constitution in childhood or infancy, we should advise the parents to resort to the proper treatment, in order to develop a healthier and stronger constitution; for, as we have seen, in those who have an inherited tendency, or an acquired debility, there is a marked susceptibility to have phthisis developed. In such cases an attack of lung trouble, which in a healthy individual would disappear in a short time, is apt to remain and effect such changes in the epithelial lining as will lay the foundation of catarrhal phthisis.

In order to prevent the development of phthisis, to increase the constitutional health and eradicate weakness, there is nothing so important as proper hygiene. If there are any great and radical differences between the practice of to-day and that of fifty years ago, it is in the more accurate diagnosis and the broader views of hygiene, as bearing upon treatment, that have been introduced. Nowhere do we see this more marked than in this group of diseases.

Sunlight, pure air, proper gymnastic exercises, regular out-door exercise, maintaining the tone of the skin by bathing and friction, and if necessary, a change of residence to a more suitable climate, are the elements that are able to convert a feeble system into a vigorous one, and which, when there is a commencing predisposition to phthisis, are able to overcome and eradicate it. The same thing is true after the patient is taken with catarrhal or croupous pneumonia.

Now, as long as it was the habit to think of phthisis as always tubercular and always associated with this special new growth in the lung, the treatment was practically regarded as hopeless, and it was thought that all that could be done was to render the patient as comfortable as possible and treat the special symptoms as they appeared; but now, since we know that phthisis, in

the majority of cases, at least in the beginning, is not tubercular, and that it may run through its whole course without the development of tubercle, its treatment becomes of extreme importance. If a person with a feeble constitution gets an attack of catarrhal pneumonia, we must regard him as liable to pass into a state of phthisis; and this is true, not only of severe attacks, in which, perhaps, the whole of one lung or large portions of both are involved, but also of those involving small and circumscribed portions of the lung tissue, which so frequently occur and are regarded as common colds.

Catarrhal pneumonia of this latter type will be one of the most frequent diseases with which you will meet, and it must be treated vigorously. The patient should be absolutely confined to bed. Rest should be insisted upon until the physical signs of the local disease are removed, or until the disease, despite our efforts, has passed into a chronic state. Local counter-irritation and depletion should be employed, by dry cupping, or if the fever be high, and the patient pretty strong, wet cupping, and by blisters, or counter-irritant applications. I do not want, to-day, to enter upon the treatment of catarrhal pneumonia, but desire to dwell upon the importance of rooting out this disease at its very beginning, the importance of regarding it, as it really is, of an inflammatory character, and the danger of the exudation passing into a state of cheesy degeneration. If you treat this disease actively, you will be able, in many cases, to prevent it from passing into phthisis.

Suppose, despite your effort, the disease passes into the chronic form, or that the patient does not come to you until it has reached this stage; for in five out of six cases you will find a history something like this—the patient has had a severe cold, which settled on his lungs, he has been gradually losing strength and flesh, has, perhaps, a little fever, and on examination you will find evidences of local catarrhal disease. Here there has been these limited catarrhal attacks, which have attracted little attention, and have slowly passed into cheesy degeneration, with perhaps disintegration of the lung tissue. Here, again, we find the immense importance of a proper hygiene. I think our power of successfully treating these cases depends upon our power of getting the patient to understand that we cannot cure this condition by drugs. The truth is that the general health is so impaired, and the tone of the system is so reduced, that instead of the inflamed epithelial cells being able to throw off the catarrhal product and return to a healthy grade of action, they tend, more and more, to pass into this unhealthy state, the matters undergo cheesy degeneration, the lung tissue becomes involved, and phthisis is developed.

Secondly: in consequence of this extreme weakness of system, there is a great susceptibility to changes of temperature, damp, and other depressing agents, so that he is constantly getting, from the most trifling causes, fresh attacks of congestion and catarrhal inflammation, which extend the original trouble. This weakness of system is what you have to meet by your treatment. In the great majority of cases, when they first come under notice the local trouble is so slight that if the system was in a healthy state it would be thrown off in a few weeks. As soon as you have gotten the patient to grasp this view of the subject, and to make it his business to endeavor to build up his general health, you have accomplished a great deal in the treatment.

In speaking of the hygienic treatment of phthisis, I shall allude to only one or two points. All the conditions that predispose to phthisis serve to maintain it. The study of the skin and its circulation is most important, for a loss of tone of the skin constantly predisposes the patient to take cold, the cutaneous circulation is checked, congestion of internal organs takes place, and extension of the local trouble results. I would say, then, that our care should first be directed to improving the tone of the skin, and the surface circulation. For this purpose you will find a cold sponge bath, or a plunge bath taken every day, at suitable times of the year, a very important measure, and one which I think is too often neglected. The best way to take this bath, is not to take it in the slow desultory manner of an ordinary bath for cleanliness, but to take one quick plunge, in and out in a second, and then to dry the surface rapidly by vigorous friction. Where the patient is too weak to do this, sponging with cold salt water may be substituted. The time of day when these baths should be taken is important. They are usually taken in the morning before breakfast, but this is wrong. They should be taken some time after breakfast. Suppose the patient has breakfast at 7.30 A.M., or 8.30 A.M., then 11 A.M. is the best time for the bath, as at that time the power of reaction is at its best. In many cases, where the patient has his business to attend to, this time is not suitable. In such cases the bath should always be taken in the morning. There is a great amount of good to be gained by this mode of treatment, if properly carried out.

In cases where there is an almost invincible tendency to take cold, with feeble circulation, cold extremities, a skin that is delicate, dry, and exceedingly sensitive to changes of temperature and humidity, I have found inunction of oil into the skin, over the whole surface of the body, after the bath, of the greatest possible value. In many instances it will render the patient proof against these changes.

Diet and exercise require fully as much attention as does bathing. Let me here refer to the importance of abundance of fresh air. Note that these attacks of congestion depend more upon feebleness of the circulation than upon anything else, and that anything that renders the circulation less vigorous will make the attacks more frequent. If the endeavor is made to protect the patient from exposure by keeping him shut up in a warm room, the susceptibility will only be increased, so that no matter how warmly clad the patient is he will not be able to resist the slightest exposure. The only way to protect the patient is to increase his strength, and thus enable him to resist these changes. If the patient is too weak to carry out the proper measures to increase his strength in the climate in which he is living, he must change it for a more suitable one. Exercise in the open air is absolutely necessary. It should be taken every day, about the middle of the day, except when the weather is stormy, blustery, or so intensely cold that the patient would be chilled at once, for cold of itself is not so injurious.

Closely allied to the question of exercise is that of change of climate. The greatest fallacies exist as to the reasons for, and the objects gained by, a change of climate. The climate of one place is essentially the same as that of another, leaving out, of course, all consideration of malaria, filth, etc. What you induce a patient to change his climate for, is to place him under better conditions to practice the same hygiene and therapeusis as he would at home. The change of climate is not going to do anything, directly, for that man's trouble. If he should go to a suitable climate and think that then he had done all, leave off all his hygienic measures, fall into irregular habits as to eating, sleeping, etc., it would have been far better for him to have remained at home.

Change of climate is exceedingly important under two conditions. In the first place, when the climate in which the patient lives is one where there are long periods of inclement weather, as, we will say, in this city during the next ninety days, to the first of April, where it is doubtful if much out-door exercise can be had. A climate like this is not suitable for such patients. Again, if the patient is so weak that he is unable to bear much cold, even if it be dry cold, he must be sent to a milder climate. Change of climate is, then, not to be regarded as possessing any curative effect in itself, but simply as an assistance in carrying out the proper hygienic and remedial measures, and to be resorted to when the patient does not respond to these measures in the climate in which he is. Diet, dress, out-door exercise, gymnastics, mostly in-doors, and proper bathing, are then essential elements of our treatment, and lie at the bottom of all successful treatment.

Now, after all these are attended to there comes up the question of therapeutical remedies. There are two principles that would occur to all in the thinking what we would do in a case of phthisis; one is, that we should aim at improving the general strength, the other, to aim at removing the local disease. The patients are always reduced in health, and this would at once suggest the use of nutrients and tonics. The best nutrients are food and fresh air; besides these we have a number of other valuable remedies, as iron, malt, alcohol, glycerine and cod-liver oil. They all are analeptics. They supply material from which the system can build up its tissues, and when the patient is able to digest these articles, in addition to his ordinary diet, they may be given with great advantage. They do not exert any specific action upon the local disease. They produce their effects upon the general nutrition, and thus tend to restore a more vigorous grade of action to the affected cells, so that they will produce more perfect cells. On the whole, there is perhaps no remedies of this class so generally applicable as the oils, and of these, the best is cod-liver oil. It is to most persons very digestible, and can usually be given by some device that will conceal its taste. If the patient falls off in the quantity of food that he takes when taking oil, he had better give up its use. It is only of advantage when it does not interfere with digestion, when the patient is able to take his full quantity of food, and when the oil is easily digested. The same is true of all other remedies of this class. They furnish the same elements of nutrition, in a concentrated form, that we have in milk, beefsteak etc.

In many cases, where the digestion will tolerate it, iron is of extreme value, and perhaps in such cases our choice of the preparation to be used will depend somewhat upon the condition of the local disease. We may give it in a

simple form, if we desire only to introduce iron into the system, or in the form of the iodide of iron, where we feel that iodine would be of service for the local condition.

The same general principles would govern us in the use of tonics. They do not exercise any direct power over the local disease; but it is only by enabling the system to receive and appropriate nourishment that they do good. When the appetite and digestion are good, tonics are not needed; but when there is functional disturbance of digestion, the vegetable tonics and mineral acids are to be used upon the same principles that would govern their use, in the same condition of depraved nutrition, under other circumstances.

In estimating the progress of the case, and in governing the treatment, you have two elements to guide you: first, the quantity and the character of food assimilated; secondly, the character of the discharges and the movements of the body weight, as determined by frequent observations. Without paying attention to these points, I think little can be told as to the condition of the patient and the success of remedies.

Now, as to the treatment of the local disease. This is undoubtedly last, because it is of the least importance; yet it is very important; and I think great good can be done by addressing ourselves to its treatment. Counter-irritation is, I think, of great value throughout the whole course of the disease until tuberculosis is developed. As long as the disease is a simple inflammation, even after destructive disease has shown itself and a cavity has formed, I think that mild counter-irritation is of service.

Secondly, the alterative effect of inhalations is of unquestionable advantage. A great variety of inhalers and a great variety of remedies to be inhaled might be recommended, but your own judgment will guide you in the selection of the former, and your preference and the result of your experience in the choice of the latter.

Then, we use certain drugs internally, in the hope that they will modify the condition of disease at the affected part. Among these are to be mentioned mercury, iodine, and arsenic, as the most potent. There is great difference of opinion as to the use of these powerful alteratives in phthisis, and in discussing this subject we are treading on delicate ground. There is no doubt that if we had to control only the acute disease, where destructive lesions had not shown themselves, we would resort to these drugs, if we did not dread their interfering with digestion and destroying the strength and vitality; and just as we find the strength and vitality well preserved, do we feel justified in using these remedies. Take, for instance, a case of croupous pneumonia, passing into chronic solidification of the lung, and where you fear that it will pass into caseous degeneration and phthisis; here, I think, you will find mercury, associated with alkaline expectorants, very useful. It may be given in the following combination:—

℞. Hydrarg. bichloridi, gr. $\frac{1}{48}$–$\frac{1}{36}$.
Ammonii chloridi, gr. v–x.

This may be given dissolved in syrup of acacia, or some other vehicle. Instead of the muriate of ammonia you may substitute the iodide of potassium in doses of from two to four grains. In cases, then, that have a marked inflammatory beginning, particularly if attended with a considerable amount of solidification, which becomes more or less permanent, and where you fear that the exudation will pass into cheesy degeneration and terminate in phthisis, you will find counter-irritation and the use of mercury and iodide of potassium of extreme value, associated, of course, with the most minute attention to hygiene; for we must not forget, while we are trying to remove this local effect by drugs, that the ultimate result will depend upon the maintenance of strength and constitutional vitality.

You will more rarely be led to employ mercury in catarrhal pneumonia threatening to pass into phthisis, than in croupous pneumonia; still, there are a number of cases of a catarrhal character where the local signs will remain obstinate, and there is a limited patch of solidification, where the general strength is not much impaired and other remedies have failed, in which minute doses of mercury may be used with great advantage. In such cases I usually employ the protiodide of mercury in minute doses, one-eighth to one-sixth of a grain, associated with a vegetable tonic, as the extract of gentian, or nux vomica. I do not think that minute doses of mercury given in this way exert any very depraving effect upon the constitution and nutrition, while I am satisfied that they greatly favor the absorption of inflammatory products, whether croupous or catarrhal, which will not yield to simply alkaline and resinous expectorants. But I say you are treading upon delicate ground in the use of these powerful remedies, and I do not mention them except with the most strenuous caution, that they should only be used under the most watchful supervision, and in carefully selected cases.

We have as other remedies favoring the removal of these products, the alkaline expecto-

ants. Of these, the muriate of ammonia is at once the most accessible, the most used, and as good as any other. It may be given in pretty large doses without interfering with the digestion. It enters into the composition of a great many cough mixtures; and just here let me say, in regard to cough mixtures in phthisis, that I think, as a rule, they are better omitted. I do not know what good is to be done by giving the patient large quantities of syrup of tolu, of squills, or of senega. If the patient has a bronchitis with his phthisis, and if there is a large quantity of ropy mucus, keeping him constantly coughing, and disturbing his sleep at night, you may, for a time, employ these stimulating and somewhat nauseant expectorants; but such remedies as these do not possess any decided alterative effect upon the diseased lung tissue, while we know that they lessen appetite and interfere with digestion, and they should be therefore used only for the temporary purpose of relieving the bronchitis. If we are to get any benefit from remedies in phthisis, I think that they must be given in a simple form and in pretty solid doses.

We come now to a question closely connected with this, that is, the use of opium in connection with expectorants and alteratives. I think that opium should be avoided as long as possible in phthisis. Undoubtedly, the continued use of opium, even in small doses, is injurious to digestion and nutrition; but there are certain conditions that call for its use. These are, a tendency to diarrhœa, intense irritability of the air passages, constant irritative cough, extreme nervous irritability and wakefulness. These, particularly if connected with marked febrile action, are much benefited by minute doses of opium. Opium is to be used, not as a remedy for phthisis, but to meet certain definite indications, and its use is to be discontinued as soon as the indication has been removed.

Returning to the alterative expectorants, there is a very good preparation in the market, known as the compound syrup of the hypophosphites. I refer to the preparation without iron. This is a combination of the hypophosphites of soda, magnesia and lime, with free hypo-phosphoric acid. It is a tonic, stimulating the digestion, and at the same time, I think, exerting a favorable action on the epithelial cells, softening the secretions and rendering expectoration easier. This preparation will often be well borne by the stomach when all others do not agree.

The other alterative expectorants are drawn from the class of resinous substances. The most useful of them being tar, carbolic acid and yerba-santa. Purified tar, taken either in emulsion or in capsules for a long time, in cases of chronic catarrhal phthisis, is often well received by the stomach, stimulates digestion, and I think exercises some alterative action over the local disease. It is evidently absorbed, for its odor can be recognized in the various secretions, and if its use is continued for a long time, it may, in its excretion from the lungs, modify the local disease. This is also true of carbolic acid, but its effect is not as good as that of tar.

The best of this class is, perhaps, yerba santa. This is a remedy lately introduced. It is the *eriodyction glutinosum*, a native of and indigenous to California, and furnishes a resinous extract. It may be prescribed in the form of the fluid extract, and it possesses in a higher degree the power of turpentine and copaiba. It is non-irritating to the stomach, stimulates the appetite, may be given in full doses without causing disgust, and probably exerts a mild local alterative action. When you think it not advisable to employ mercury and iodide of potassium, you may use a combination something like this:—

℞. Ammonii, chloridi, ℥ iij
Ext. eriodyctionis, fld., f. ℥ j
Syrupi pruni virg., q. s. ut ft f. ℥ ij. M.

Sig.—A teaspoonful every three or four hours.

If necessary one grain of muriate of morphia may be added to this combination.

The old expectorants, as squill, senega, etc., I would relegate to a back group, to be used only for occasional attacks of bronchitis.

I have now alluded to the most important remedies for the treatment of phthisis; and perhaps I have said enough upon this subject, for, after all, in a course of lectures like this, it is only possible to present the thoughts that fill one's mind, and you will have to work out the details of treatment for yourself. There is no invariable and fixed line of treatment, but each case must be treated according to its own indications.

I will allude to only one thing more, in conclusion. Sometimes, after you have pursued this treatment as long as possible, you find that the general health remains pretty fair, the local disease remains about the same, does not tend to spread through the lung, a cavity has perhaps formed, purulent expectoration is still kept up, and the patient's strength is slowly being worn out, but yet your remedies do not seem to arrest the disease. Under such circumstances, local treatment is very desirable, and after inhalations had been tried and abandoned, I should resort to another form of local treatment, by the intro-

duction of a hypodermic needle through the chest walls, and the injection of stimulating substances into the diseased spot. This plan of treatment I consider only applicable in rare cases. The group of cases in which inter-pulmonary injections are to be used is very circumscribed and well defined.

It includes only those persons who have a local circumscribed spot of disease which does not disappear, and particularly if a cavity has formed, whose general health is still fair but is slowly breaking down, and where hygienic and therapeutic means have been tried without success. These are the cases in which inter-pulmonary injections may be used with benefit and without risk to the patient.

This whole subject is one of great fascination, and of intense interest to me, and you will all probably see more of this disease than of all others put together. You will everywhere meet with the questions we have considered, confronting you, and I have no doubt that the more you study these cases the more you will find that you can do for them. I am sure that by taking hold of these cases vigorously, bearing in mind the great importance of hygiene, and combining sound hygiene and rational therapeutics, you will be able to effect a complete cure in many cases, and even in the worst cases do much to improve the comfort and lengthen the life of your patients; and your treatment will be so satisfactory to yourself and your patients, that it will amply repay you for all the time you have spent upon this subject.

Communications.

REMINISCENCES OF A VISIT TO EUROPE IN 1879 (Continued).

BY LAURENCE TURNBULL, M.D.,
Of Philadelphia.

Munich, September 20th, 1879.

Resuming my diary, I first find note of a most delightful visit to the hospitable country mansion of my friend, Dr. Weber Liel, who resides on the Rhine, at Mallander, above Coblentz. The doctor and his charming lady, who, by the way, is an American, did everything they could to make my visit an agreeable one. While enjoying Dr. Weber Liel's hospitality I had frequent opportunities of discussing many interesting points in regard to the physiology and therapeutics of the ear. I had already made use of some of his ideas in my work on "Tinnitus Aurium," 2d edition, advising in certain forms tenotomy of the tensor tympani. He was the first who clearly pointed out the great importance of the palato-tubal muscle, and that patients who suffer from progressive deafness have antagonistic contraction of this muscle. A recent case of deafness after an operation for cleft palate was reported by my son, and it was only overcome by prolonged and persistent treatment. In Dr. W. Liel's valuable work, "Progressive Schwerhörigkeit," Progressive Deafness, he gives a most accurate account of the complicated anatomical and physiological relations of the Eustachian tube and its muscles. These facts have been confirmed by others. Credit is due to Dr. Woakes, who directed the English reading physician more particularly by dwelling clinically on paretic deafness, in his work published in January, 1879. Then in a paper read by the same authority before the Otological Section of the British Medical Association, and which was discussed by Dr. Liel and others. Still more recently, in the second edition of his work, in which he gives full credit to Dr. Weber Liel, as follows: "I find myself quite in accord with the statements advanced by Dr. Weber Liel. The cases observed by me and discussed in the paper referred to, present some striking points of divergence from the disease described by this author as 'progressive deafness,' and which divergence will be apparent by the tabular comparison of symptoms given below, of the two classes of cases."

SYMPTOMS IN PROGRESSIVE DEAFNESS (WEBER-LIEL).

1. Paresis of palate muscles connected with middle ear.
2. Characteristic signs in palate.
3. Antagonistic contraction of tensor tympani, inducing
4. Depression of membrana tympani, with indications of permanent retraction of tendon of tensor tympani, coming on slowly.
5. Deafness, slight at first, gradually increasing, with intervals of abatement.
6. Noises, constant.
7. Giddiness, recurring at intervals, a constant symptom.
8. Progress, slowly, to complete deafness, but curable in early stages.

SYMPTOMS IN PARETIC DEAFNESS (WOAKES).

1. Paresis of tensor palati and lavator palati.
2. Characteristic signs in palate.
3. Paresis of tensor tympani (probably also of stapædius).
4. Membrana tympani to remain nearly normal in appearance, but deprived of its "accommodating" power.

5. Deafness well-marked from first.
6. Noises, exceptional.
7. Giddiness, absent throughout.
8. Progress quickly to recovery.

September 21st, started from Mallander House, the home of the Liels for several generations; thence to Coblentz, and took a run to Bonn, to look at the statue of Beethoven, situated in the market place, and also visited with much interest the house in which that most distinguished musician was born. Took the cars along the banks of the Rhine to Mayence, and from thence to Munich, arriving at eight A.M., after traveling all all night. The cars were very comfortable, so that I was able to sleep until five A.M., when the light and constant changing and noises kept me awake. There is much to be seen in Munich; besides the permanent galleries of pictures and statuary, there was an international artists' association exhibition of pictures, engravings and statuary. I repeatedly visited this fine collection, which numbered 2392 pictures. There was also the finest collection of wood engravings and illustrated works. The collection was in the Crystal Palace, and at the conclusion the works were distributedby raffle, and the tickets were sold at a moderate cost. On the following day, and for a week, visited the wonderful, and in many instances, splendid collections of artistic buildings, with their numerous frescoes, etc., and on Sunday the Haedhauser Kirche and the Basilica of St. Boniface, the latter one of the most perfect of the many creations of king Louis, of Bavaria, who was a great patron and lover of art. After spending the early Sunday morning, called a passing cab (Droschke) a one-horse vehicle, and was driven to the English church, some eight squares, for 50 pf., equivalent to six cents, or half a mark. The church service was held in a building called the "Odeon." On the ground floor, on the opposite street, there was a concert; most of the populace were out of doors, the public buildings were open, and at six o'clock one of the operas of Wagner was to be performed.

In the afternoon, in company with a friend, I took a walk along the banks of the river "Isar," from which I could see the Alps, and then to the English Garden, formerly a marshy woodland, now a beautiful park, five miles in length and about two miles broad. The first attempt at redeeming this place from primitive wildness was made by the celebrated philosopher, Count Rumford, an Englishman, who presented it afterward to his favorite elector, Charles Theodore, in 1789, and the improvements were followed up and completed under Maximilian Joseph I. Several branches of the rapid rolling "Isar" have been carried through the garden, and are crossed by pretty rustic bridges; also a number of pretty lakes with Chinese towers and cafés invite the tired and weary to refresh themselves. On the following evening I went to hear Gungl's celebrated band, and looked upon the lower classes enjoying the music, but, at the same time, always either eating or drinking. Gungl is as bright as ever, and wields his baton with as much success as he did on his visit to our Centennial. Munich is a most interesting emporium of art, and much time can be well occupied in looking at the wonderful productions of ancient and modern works of art. The frescoes interested me very much, being as fine as many of our best paintings on canvas.

It is very difficult, in such a city as Munich, to withdraw from the fine arts; but one of my objects in visiting this interesting city was to see Professor Rüdinger, the famous anatomist, and look upon his perfect dissections of the human body in the School of Medicine; and especially interesting was it for me, as his collection contained the valuable sections of the head in which are shown the true position and characteristics of the human tympanum and Eustachian tubes. I compared them with the photographs of these sections which I have in my possession, and was happy to find that my pictures gave me a better idea than the sections, because the latter were beginning to change by the action of the diluted alcohol and the light. There are numerous most perfect preparations in this collection which are well worthy an especial visit and careful study by physicians from the United States.

After a week's sojourn at Munich, to which I afterward returned with pleasure, on my way back from Vienna, desiring to again see its wonderful collections of ancient products, obtained from every portion of the world, and arranged chronologically with so much care, for study and research, I left for Vienna.

The journey to Vienna was a long and fatiguing one—276 English miles from Munich—and yet it was interesting. The fine weather and a perfect sunset combined, so that I could count from fifteen to twenty peaks of the Austrian Tyrol. As we left Bavaria, which we did at Salzberg, the soil became better, and produced fine green fields of clover, etc., even late in the season.

They use a very ancient plough, drawn by oxen, and the women, as brown as berries, were doing most of the out-door labor, dig-

ging potatoes, etc. The stations were often very pretty, and as our progress up the mountains was slow we very frequently would stop near front porches which were covered with flowers, creepers, etc., and on which were stands covered with grapes in tempting clusters, pears, apples and peaches, with wine, beer, coffee, and substantial articles, for those who desired them.

I arrived at Vienna late at night, and after paying my fare to cross the bridge into the city, the cabman drove me to the Grand Hotel, which resembles an American hotel in its conveniences, having some three hundred rooms, and an elevator to all the floors, with bath, telegraph, and a most admirable restaurant in the centre of the court, covered with glass; all under the careful management of a most competent gentleman, Mr. F. Sommer. After a comfortable warm bath and good bed awoke refreshed, and obtained a good breakfast à la carte. The porter, a most important and generally very intelligent and polite individual, gave me all the information desired in regard to Professors Gruber and Politzer, and the University of Vienna. He then obtained a carriage for me, and the first visit I made was to the celebrated aurist, Professor Joseph Gruber, whose office and residence was at "Neuer Markt," No. 2, a four-story building in flats, with numerous persons occupying each floor. On ringing the bell the porteress came to the door, a middle aged woman, and informed me the Professor was to be found on the third story. I went up and rang a bell, and was ushered into a small vestibule with a cloak rack, and a quiet German man took my card to Professor Gruber, up stairs, and soon returned and ushered me into his reception room, which was well filled with patients of the better class, waiting for the Doctor. The room was furnished with taste, with numerous pictures, cabinets, etc., and comfortable chairs and sofas, with windows looking on the street.

The Doctor soon arrived. His step is brisk; expression pleasant; short, thick hair, well sprinkled with gray; very bright, dark eyes, and rather a low forehead. On entering the waiting-room he called out my name. I arose, and he grasped my hand with great warmth; he was evidently pleased to meet me, and ushered me into his private consultation room, and again took both my hands in his and told me, in very good English, how glad he was to see me, and then inquired after his pupil, my son. He also informed me that he had heard of me in Cork, at the meeting of the Section of Otology, of the British Medical Association. I then made an engagement with him for the following day, to come to his house and visit with him the celebrated Hospital, and was driven to the various points of interest, visiting the public buildings, churches, etc. Also took the tramway, after dinner, as they call the passenger railroad, and visited Prince Rudolph's bridge, over the Danube. I could not help noticing, as I went along, the remarkable brown hue, almost negro like appearance, of the working people who were employed in the streets —both men and women—and the extensive use of dogs as beasts of burden. Boys and men harness themselves in company with huge, strong dogs, and by means of long, flat wagons, convey very large and heavy loads of goods to the various portions of the city. Some of the dogs are very large and are made pets of, and often destroy the smaller ones, especially the black dogs, the owners of which have to pay for them. Even the celebrated Prince Bismarck, when he came to this city on a visit, brought with him his famous dog "Sultan."

An unpleasant peculiarity of this city is the dust of the streets, which enters your nose and mouth, and passing into the bronchi causes irritation and inflammation of the mucous membrane, and in conjunction with the cold, damp air, has a strong tendency to induce phthisis. The material which they use on their streets is lava, which is like emory, fine and very sharp, no matter how small it is pulverized, and causes a running from the nostrils, with sneezing, from which I suffered, as almost all are apt to do.

One of the most magnificent buildings in Vienna is their Opera House; equal, I think, to the beautiful one at Paris. I had an opportunity of seeing the opera of "The Queen of Sheba," by Goldmark. It was superbly rendered, with two prima donnas and a splendid orchestra, with a full chorus of well-trained voices.

[*To be continued.*]

Hospital Reports.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

A CLINIC, BY FESSENDEN N. OTIS, M.D.,
Clinical Professor of Venereal Diseases.

The Diagnosis of Syphilis.

We have one or two cases, gentlemen, that I saw in passing on my way into the lecture room, that seem to make it worth while to consider the value of time as an element of diagnosis in venereal diseases. You know there is a characteristic difference in time between the appearance of the two diseases, chancre and chancroid. Chancroid commences to show a destructive action at once

on contact, so that we expect to find positive, well marked evidences of chancroid long before we would have evidence of syphilitic disease. This destructive action commences at the moment of contact. It begins by setting up a necrosis, which first shows itself in a congestion of the parts, then as a perceptible destruction of the part, visible under the microscope before it is perceptible to the naked eye, commencing as a minute point, and then extending by a rapid process of molecular degeneration. The highest type of ulcerative action is this chancroid. We are accustomed to talk about the chancroid having an incubation of three to six, seven, or eight days. This is a very loose way of talking. There is no such thing as an incubation, either in the chancroid or in the chancre, as we shall see as we pass. But in chancroid particularly, there is no reason for calling it an incubation, when it is only because it is so small that your attention is not called to it at first. The sore is there at the commencement; it is very small when it attracts your attention; it may not be until four, six, or ten days. But when a sore appears as an ulcerative lesion within ten days, where we generally find these sores, on the penis, then we say this is a chancroid. We say it is a chancroid, because of the time which has elapsed from the time of contact up to its characteristic development. So, time is a valuable element in making up our minds. Now, if, before we find anything that is characteristic, twenty days, fifteen days, fourteen days, anything over ten days, have passed, we say that is very suspicious; that may be something else. What else? Why, true chancre; syphilitic trouble; the initial lesion of syphilis. And that is a lesion which becomes in a sense ulcerative, as I have explained to you, but has an entirely different nature, ulceration connected with it being one of two varieties, either accidental, as the result of superimposed trouble upon the original condition, which obscures it, and not connected with it except in that sort of way, or caused by a disturbance of the circulation in the part, from the accumulation of material which has been growing at that point. I cannot tell you too often of this difference, which so many have been in error about heretofore; that the one is a process of ulceration, of necrosis *per se*, and the other is a process of proliferation, which results in a lesion from the fact that there is so great proliferation that the tissues are filled up with the cell material, and the vessels of nutrition are choked, and a molecular necrosis is the result. This comes on later. We do not look for the accumulation of cells as a characteristic of the initial lesion of syphilis before the twenty-first day, and then we find it not necessarily as an ulceration, except the ulcerative lesion is not the initial lesion of syphilis, but we find it as a little nodule, a little papule, without any breach of tissue whatever. This is just as important, and may never be anything else. It may pass away without ever having come to an ulcerative point at all. That is the way it begins.

Now, in some cases this very soon breaks down, from a cause that I will tell you of, and there appears an ulcer there. We look at it, and say, well, what is that? Well, when it does appear, if it come, three, six, eight, ten days after connection, then we say it is chancroid. Whatever else there may be about it, it is chancroid, probably. But after twenty or thirty days have elapsed and you find such a lesion, then you hesitate; you stop to inquire into it; you make the matter of time an important point in your diagnosis.

When did this trouble first come to your notice? "About three days after connection." Had you any connections previous to that? "Yes sir, about two months previous.

Now here, you see, is a point of importance, gentlemen; and it is things of this kind that are so necessary to be borne in mind when you come to make a diagnosis and prescribe treatment. A man comes to you and says, "here is a sore which I got from a woman three days ago." Now, perhaps he did and perhaps he did not. There is one thing very certain about it, *he thinks* he did. Now he has had connection two months before, perhaps (not referring to the reply of this patient); but two months before he had connection with a woman whom he had full confidence in; he does not think it possible that he could have contracted the disease from her; yet he may have acquired a syphilis from her, that has gone on in this clean little papular sort of way, not attracting his attention until he had connection with another woman whom he suspected might give him disease, and then he begins to watch, and two or three days afterward he sees this little sore.

It is not well that we accept the simple statement of the patient, that this sore is the result of contact three days before. We must look back, and see whether there may not be something behind that, and that this recent connection has simply called his attention to a trouble the result of a former connection; that it is really a lesion of syphilis and not a more innocent trouble. We may thus be saved many mistakes which have excused patients in doing things which they would not have done had they known the real nature of their disease.

Now let us see what you have here. You had no connection at all in the interval between your last connection and the one two months previous? "No Sir." This matter of diagnosis, gentlemen, is one well worth our spending some time upon. Very much mischief has been done by mistaking the initial lesion of syphilis for sores of other varieties, as chancroid, or a simple lesion. It is a very grave matter to overlook syphilis, and give your patient to suppose he has nothing but a simple lesion, and when the simple lesion heals he thinks that is the end of it, and then subsequently his trouble proves to be something else, and perhaps he does not find that out until he has infected somebody else.

Now, here we have some little points of ulceration—sharply cut little points; here is a sharply cut loss of tissue over a distinct depression; and here there is another of the same kind which is covered up by a little unhealthy granulation. Now, those of you who wish to come nearer will see there a little chancroid; it is very small; it would not attract attention, perhaps, but for the fact that the chancroid is tender; it has an inflamed border, and one of

its characteristics is its sensitiveness. Now, that is characteristic of about the third or fourth day from its first appearance as a little pimple. This little sore here he had not noticed, because it was in a fold of the mucous membrane, and is very small, about the size of half a pearl of barley; and he is getting some more little pimples. Now, here we have this form of ulcerative sore sharply cut, with an inflamed border, and it is very tender; that is one characteristic of it; and then there is another characteristic of it which is present here, that there are several little pimples; it is a multiple lesion, which is characteristic of this form of trouble, because the secretion of it is probably setting up the same destructive action that is characteristic of the original sore. Now, the secretion in the initial lesion of syphilis has no such property in itself. The secretion of the initial lesion of syphilis is a bland, transparent fluid, introduced upon the surface of the skin, the mucous membrane. Under the surface of the mucous membrane of the patient it does not set up any irritation whatever. The tissues heal as if nothing of the kind were present. But if you introduce the secretion from this sore under the skin, or lay it upon the mucous membrane so that it shall lay in close contact between the folds for a length of time, by its own property of erosion it will make its way into the tissue, and set up a lesion exactly like that from which it was derived; so that the characteristics of this sore are, in the first place, the action beginning immediately after contact; then its going on as an active destructive process, its having an inflamed border, and its being sensitive to the touch; its having a secretion which is purulent (whereas the one we have just been talking about is serous); and this purulent secretion has the property of contagion, of communicating a similar action to the tissues with which it is brought in contact, and establishing a general sore; and to that property we are indebted for its multiple character, so that when you see half a dozen sores on the penis you say at once, there is chancroidal action. The accumulation of cells which brings about the initial lesion of syphilis does not occur in that way. We have but a single one, as a rule. Sometimes there are more. Where the inoculation takes place at different points we may have several initial lesions of syphilis, but this is rare. Inoculation usually takes place at a single point, and the cells heap up at this point, and finally make themselves manifest by a papule, which may or may not go on to an erosion or apparent ulcerative action.

This young man, then, says that this came on three or four days after connection. You can understand now why it has done so. All that was required was time enough for the infecting material to make its way into the tissue. Now, this length of time varies in different cases. If it happens to be upon the skin of the penis where it is whole it may stay there for some time: and if the man is cleanly in his habits it may be washed off and there may be no evidence of it at all, he may not suffer from any trouble whatever; but if it gets in a fold, as you see it here, when the prepuce is drawn back, where the skin naturally falls in folds, it may after a time get up an ulcerative action. It is slow in such a case as that, and you may be deceived. It may be ten or fifteen days, or even longer, possibly, after contact before the sore comes to such a point as to draw your attention to it. But the common place for the occurrence of this sore is in the mucous membrane, the semi-mucous membrane of the reflection of the prepuce as it folds around the frænum, in the little sulci that are formed on either side of the frænum just at the commencement of the fossa glandis. This is the favorite seat, because here the wrinkles are numerous, the skin is very tender, the sebaceous follicles are numerous, the parts are constantly kept in a moist condition, and this is most favorable for the action of the virus. The consequence is, this is the very common locality for the sore, around the fossa glandis; or it may occur at any point of abrasion, at any wound; and this latter is the way in which we find the sores appearing within a very short time after contact. Perhaps within twenty-four or forty-eight hours there may be evidence of suppurative action where there has been a wound produced and the delay for the virus to work its way through the superficial covering has not been necessary.

This seems to have required three or four days from the time of contact until he noticed this trouble in the fossa glandis, the first one; and the others have come on since. But let us inquire into it thoroughly. When did you have the connection? "About six weeks ago." The connection to which you attributed this? "Yes, sir." And how long after connection did you notice something? "About four days." Was it this sore here? "No, sir, it was a running." Then it was not a sore that made its appearance three or four days after connection? "No, sir, it was a running."

Why, we have here a complication, and we are reminded of the fact that we may have several diseases acquired at the same time, at a single connection. He may get a gonorrhœa, he may get a chancroid, he may get an initial lesion of syphilis, all at once. There is no law against it, either pathological or physiological. This sometimes occurs. A single instance of this kind I can recall, where a very amiable young gentleman came down here to visit his brothers, who were used to the ways of the city. He was troubled with seminal emissions, and his brothers thought it would help him to have connection. So they took him out one night, in order to cure him of his seminal emissions? very much against his sense of right. His moral sense was considerably disturbed about it, but he was over-persuaded, and went *just this once*, and after that he could not be persuaded. But three or four days afterward, he began to have a discharge, such as this young man seems to have had, and then three days after that he had some chancroids, and about fifteen or twenty days following one of these chancroids indurated and became an initial lesion of syphilis. Now, that is not uncommon. It is not uncommon for several diseases to be acquired at once. These diseases may coexist, from the fact that one, the gonorrhœa, is a disease of the mucous membrane;

it is not associated with ulceration; the other, chancroid, is an ulcerative process which comes from contact with a similar ulcer; and the other disease, syphilis, may be engrafted upon any sort of lesion. It is well, perhaps, to say in passing that it is not so likely to take place in active chancroid, and I question very much whether it ever does so except in a way to be mentioned immediately, from the fact that the cell which produces the trouble would be very likely to be destroyed by the active virus. But the way in which it does occur is that the syphilitic cell enters an abrasion, and it does not take a great while for it to get down out of reach of any chancroidal action. In this way, before the chancroidal action is fairly set up, the syphilitic cell has dipped into the lymphatic channels, and deliberately goes on to build up its characteristic accumulation until after the chancroid has healed and got out of the way, when a little nodule is left there which is significant of syphilis.

These things render it somewhat difficult in many cases to make out what disease we have before us, because they are associated with each other, superimposed upon each other in some cases, and consequently it becomes necessary for us to analyze these cases with very great care, and to seek out the landmarks which will enable us to decide positively as to which disease or how many of them are present in any given case.

Now, here, four days after connection, we find this young man complaining of a running. Did that smart you? "No sir, it only run just the least bit."

Well, now, you see we have constantly to change front in getting over a case like this. We find something which seems to promise one trouble, and looking a little more carefully into it, we find it is something else. I supposed from what he had said, viz., that the trouble followed three or four days afterward, and that it was a running from the penis, we were going to have a case of gonorrhœa from which he recovered; but this seems not to have been the case, for it seems now he had this running lasting a day or two only. If you have a gonorrhœa lasting only that length of time you are surprised at it; three or four weeks is more like the truth. But where it stops like this, it must belong to some other trouble. It may be a little leucorrhœa which starts up, irritating the mucous membrane, and passes off in three or four days; there are plenty of such cases. It may be a little deposit of chancroidal virus within the meatus, out of sight, and here the irritative action goes on, and the first you notice is a little weeping. The man thinks he is going to have a gonorrhœa. But his discharge does not go on and increase from day to day in that sort of way, but his penis is a little bit sore and a little red; perhaps he may notice a little bit of blood, if he has a pretty tight meatus, and if he looks carefully, opening the meatus, he will find a little lesion, a little chancroid.

That running passed off; did it leave a sore in there? "No sir; only a little pimple." Then it got well entirely. "Yes sir." He has a small orifice, and if he had this running and it got well within two or three days, it was probably from the cause I have just suggested, a little leucorrhœal disturbance.

How long was it after the running stopped that you noticed this sore here? "About two weeks."

About two weeks then, after this, without any after connection, he had, as he says, this sore, and that has continued ever since. The history seems a little mixed, and it often embarrasses rather than helps the surgeon to make out the diagnosis. Now, we have here the history of a little discharge which came on three or four days after connection, which lasted only three or four days, and then within a couple of weeks a sore makes its appearance here. So, we may have this trouble due to syphilitic condition. That is possible. Although the length of time is unusual, yet, in some cases we do have an ulcerative lesion apparently dependent upon the syphilitic virus in cases where the suppurative disposition is very strong. An accumulation of cells in some instances results in their breaking down much sooner than in others. In the great majority of cases there is very slight or scarcely any tendency to the suppurative condition, while in others the infiltration of a comparatively small amount of cells will soon eventuate in their breaking down and becoming a little ulcerative point. When this is the case, the danger of mistaking it for a simple chancroid is very great.

The distinction that we make between a chancroid and a chancre is not an arbitrary, but a positive one. Whatever shape it may have, or whatever condition it may be found in, it must be followed by syphilis, to prove it to be a chancre. This is an absolute necessity. A chancre is not a chancre because it is a little nodule, nor because it has a slight abrasion, nor because it has gone on to ulceration, nor because it is single; but it is a chancre because it is followed by syphilis. These conditions that we associate with it, and which are common to it, lead us in the way of diagnosis; and when we find these conditions we have reason to suppose that we have the initial lesion of syphilis. But if the papule does not go on and enlarge, and implicate the glands at the groin in a peculiar way that the syphilitic trouble implicates them, if it is not followed by any syphilitic lesion, then we know that we have made a mistake; that something has occurred in this case to obscure the diagnosis, to deceive us, to give us the impression that there was a true chancre when none existed. We have to bear in mind that all the characteristics of the initial lesion of syphilis may be present without its being truly an initial lesion of syphilis. So that we have to wait oftentimes until something else has occurred, before we can give an expression of opinion in regard to it.

Now here we have, apparently, an ulcerative lesion which is somewhat indurated. This leads us to consider a point of importance in differential diagnosis. In chancroid we have simply ulceration without induration; the tissues are supple and perfectly soft. In the other case we have it characterized by a certain amount of induration, in degree, from that which simply thickens the integument to that which is described as cartilaginous hardness. This is a characteristic mark of the initial lesion of syphilis. And

yet a simple sore, a simple chancroid, may, by irritation, become indurated, so that you cannot tell the differenee between that and the initial lesion of syphilis; and this must be borne in mind. In this case, as before mentioned, there is a certain amount of induration with it. Now, whether that is the result of some application which may have been made, or whether it is the result of infiltration of cell material, is a question which we cannot at once decide. Here we have a secretion which is not a mucous secretion, which is not a serous secretion, but it is evidently of a more or less purulent character. Again, we must remember that the simple serous secretion of a chancre may be turned into a purulent secretion by irritation, and that this irritation may be the result of applications made to it of caustics, which are used for the purpose of destroying chancroidal sores. It may be the result of friction from clothes, necessarily occurring in walking, or at the patient's business. Any irritation of the initial lesion of syphilis may produce, instead of the characteristic serous secretion, a purulent secretion, which purulent secretion has the same characteristics as the purulent secretion of the chancroid, namely, to set up an ulcerative action upon the mucous membrane, or upon the parts which come in contact with it; so that you may have the initial lesion of syphilis coming on characteristically, which shall never have been mixed up with any other sort of trouble at all; a pure, simple, initial lesion of syphilis, which may go on under these circumstances and produce a purulent secretion characteristic of chancroid. Now we may find that this condition here, which came on nearly three weeks after connection, is still the initial lesion of syphilis which has been irritated up to a purulent point, and, now, within the last few days, has given rise to chancroids without any further connection. There is nothing more positively known, in regard to the history of this disease, than that the initial lesion of syphilis, irritated, produces a purulent secretion which, inoculated, produces characteristic chancroid. Mr. Boeck, the great apostle of syphilization, he who syphilized a great many individuals and demonstrated this, found that in order to get the material for producing the characteristic lesion by inoculation, in the easiest manner, he had to take the ordinary initial lesion of syphilis and irritate it by the application of savin ointment until it became purulent. Then he took this and inoculated with it until it would inoculate no longer; then he would take a fresh subject, and so on, until each patient would no longer respond to inoculation. I simply speak of this in passing, to show you how well known is this fact, that pus received from an irritated syphilitic sore possesses the property in question.

So, then, although we have these ulcerative lesions, some of which are characteristic of chancroid, and which I present to you as specimens of classical chancroid, yet we are at a loss to know whether this young man has chancroid only, or not. This chancroid here is the leading feature of the case. That this one here is an accidental chancroid we know, but he has another sore there which is at least questionable. Now, if this is truly an initial lesion of syphilis, we shall find that it has gone on in the usual way of initial lesion of syphilis; that the cell proliferation which is characteristic of this lesion has followed the track of the vessels running between this initial lesion and the groin on either side, and an accumulation of these cells has taken place. We examine on either side, and we find on this side no more than an ordinary amount of enlargement; still here is a pretty good-sized gland. There is a little more than the ordinary amount of enlargement here, on the left side, and on the right side there is quite a good-sized gland. Did you ever notice that? "Yes sir, I noticed it first recently." Has it been tender at all? "Yes sir, somewhat. It does not hurt me now."

When we brought this case before you it appeared to be a classical chancroid; it may be that we have something more important; we may have a case of syphilis; and that is why I brought the patient before you, to show you how necessary it is to follow up all the clues which present, that we may not be misled to say here is a case of chancroid which we will heal up, and let the patient go on about his business, when after a while you would learn that his trouble was not a chancroid, but syphilis. This mistake happens every day.

We have here painless glandular enlargements in the vicinity of this lesion. There is a peculiar glandular enlargement associated with chancroid which is characteristic; it differs from that of syphilis. The gland enlargement which is characteristic of chancroid is inflammatory in its commencement, inflammatory in its progress, resulting in abscess, I say, almost inevitably. Six months ago I would have said inevitably. I have taught, up to within six months, for many years, that when a gland is enlarged as a result of the chancroid secretion, suppuration is inevitable; a chancroid is at that moment established in the centre of that gland, which goes on inevitably to suppuration and the formation of an abscess, the secretion of which is chancroidal. But the experiments which were made last winter in Blackwell's Island Hospital, under my supervision—the administration of the calcium sulphide in all cases of bubo associated with chancroid—has led to the belief in the possibility of that suppurative action being arrested, because fifteen out of eighteen buboes so associated with presenting chancroids were brought to resolution. Now, we have not had enough experience on that point to state a positive conclusion, but we can say that the administration of a twelfth of a grain of the calcium sulphide every two hours during the day, to these patients, combined with other treatment, such as pressure and iodine, resulted in the resolution of fifteen out of eighteen. I speak of it in passing because I have so long and so often taught to the contrary, that they never can be arrested, that I wish to express here my doubt about it. I do not think we have experience enough yet in regard to the effect of this remedy, but I think there may be a doubt in regard to what I used to teach. At any rate, chancroid is inflammatory in its character, and its tendency is to go on to suppuration,

and it will do so unless it is combated by, as far as I know, only one means, that is, that which I have just suggested.

The bubo associated with the initial lesion of syphilis, on the contrary, never suppurates. Absolutely never suppurates, except—and all rules have exceptions—in cases of highly scrofulous nature, or where, becoming very large, they become subjected to irritation by friction, in the business, perhaps, of the individual, or from carelessness in walking, under circumstances which would almost naturally produce inflammation.

Now, here we find glands which are recognized by the patient as of recent enlargement, and are now painless. Recent painless enlargement of the lymphatic glands is evidence, very positive and strong evidence, of the presence of a syphilitic influence. Scrofulous glands enlarge slowly. Enlarged glands which come from ordinary causes, from irritation of the lymphatic vessels, from strain, and from wounds, are painful. They come on quickly, but they are painful. Here, however, they are painless, and the enlargement rapid, which is an important element in the diagnosis.

The next thing we would look for is an eruption. It has been six weeks since he had connection, so that it is too soon to look for the next characteristic of the disease which we seem to be following now, a syphilitic trouble, and that is, a roseolar eruption. Now, if in connection with this history—and here the element of time, you see, is of value—a sore, which came on nearly three weeks after connection, then followed by a painless enlargement of glands—there should follow a roseola, we should not hesitate any longer to say that the man has syphilis. But now we must wait. The case is mixed, and we must wait for time to clear it up. I do not know of any other point which will be of service to us. The whole trouble is still local. Until we get an enlargement of glands at a distance, or a roseola, we have reason to suppose that the disease is confined to this particular locality, and that he has not, as used to be believed, a disease which pervades the entire economy at once. It is a satisfaction to know this; to be assured that the approaches which it makes to the general system are slow, and they give us an opportunity of meeting the disease and obstructing it in various ways by treatment.

Let us, however, examine him for enlarged glands at a distance. We look for these enlarged glands in the neck and in the epitrochlean regions, preferably. I find an enlarged gland here on the neck, at once. This is sometimes found before we can make out any roseola.

Now, these little chancroids, when they come, are treated in the ordinary way, no matter how they have arisen; whether they have arisen from what is called the true chancroid virus or not. We will have the opportunity of setting this chancroidal virus in its proper place some day. We know it can be produced, certainly, in two ways, and I think it can be produced in a variety of ways. But no matter how it is produced, we strike it with destructive agents which are capable of destroying this peculiar property of active ulceration.

Editorial Department.

Periscope.

The Collection of Data at Autopsies.

At the October meeting of the Massachusetts Medico-Legal Society, 1879, Dr. H. P. Bowditch read a paper on the above subject, which was published in the Boston *Medical and Surgical Journal*, August 12th, 1880. He says—

Imperfect as is our knowledge of the size of the organs in an adult, our information in regard to the viscera of growing children is still more fragmentary. With the exception of the heart, and perhaps, of the liver, there is scarcely an organ whose rate of growth has been approximately determined, and yet without this knowledge it is impossible fully to utilize the data obtained at the autopsies of children.

It is, moreover, possible that variations in the size of organs, even within what are usually considered normal limits, may so affect the relations of the different parts of the organism to each other as to produce tendencies and predispositions capable of exercising a profound influence upon the life of the individual. The well-known power possessed by the various organs of the body to adapt themselves to the demands made upon them (for example, the hypertrophy of one kidney after the destruction of its fellow) will, of course, tend to restore the equilibrium of the organism, but it is by no means proved that the power of adaptation is in all cases so perfect as completely to neutralize the effect of marked anatomical variations.

Led by considerations similar to those above presented, and with a view to determining how far the various diatheses recognized by authors can be explained by anatomical peculiarities of the organism, Professor Beneke, of Warburg, has recently published the results of an investigation into the absolute and relative size of various important organs at different periods of life and in connection with different morbid tendencies. In researches of this kind conclusions are valuable, chiefly in proportion to the number of observations on which they are based, and the data at Professor Beneke's disposal were in many cases so scanty that, as he himself admits, further investigations are needed to confirm his conclusions. At the same time, many of the facts which he has brought to light are so interesting and so suggestive that it seems desirable o call the attention of this society to the matter, in the hope that a discussion of the subject may

lead to an organized effort on the part of the members to add to the data from which conclusions may be drawn in this most instructive field of study.

Some of the most important of Professor Beneke's results may be briefly stated as follows:—

1. Before the period of puberty the aorta is larger than the pulmonary artery; after this period the relation is reversed.

2. The aorta and pulmonary artery are smaller in the female than in the male, even at those ages at which the size of the body is greater in the female sex.

3. In adult males the volume of the lungs is greater than that of the liver. In adult females the reverse is the case.

4. In men the volume of the two kidneys is less than that of the heart; in women it is greater.

5. Children have a relatively larger intestinal canal than adults.

2. A sudden increase in the size of the heart occurs at the period of puberty.

7. The iliac arteries diminish in size during the first three months of life.

8. The cancerous diathesis is associated with a large and powerful heart, capacious arteries, but a relatively small pulmonary artery, small lungs, well developed bones and muscles, and tolerably abundant adipose tissue.

9. Pulmonary tuberculosis is often associated with an unusually small heart.

10. In rachitis the heart is large and well developed.

Removal of a Uterine Tumor During Labor.

Mr. A. M. Sydney-Turner, of Gloucester, reports the following interesting case in *The British Medical Journal*, July 31st, 1880:—

The patient was forty-six years old, and had had five children, all of whom were alive. She is a stout, healthy-looking woman, and seven years had elapsed since the birth of her last child. On examination I found (she being in labor at the time) that there was a tumor in the vagina, barely permitting the passage of the finger for examination of the os uteri. It was pear-shaped, with a broad pedicle, and was attached by the pedicle to the posterior half of the os. I was enabled to make out a vertex presentation; and as the labor pains were regular, but not strong, I decided to remove the tumor. With the assistance of Mr. Wilton (one of the consulting surgeons of our General Infirmary) I ligatured the pedicle with thin whipcord in two places, the upper ligature being as near to the base of the pedicle as was possible. This was done under chloroform. I then divided the pedicle with a pair of scissors, and removed the tumor. The labor came on strongly, and the woman was delivered of a female child. Before the placenta came away I examined the portion of the pedicle left behind, and found that the lower ligature had slipped; but the upper one—the one nearest the os—remained firm. A very gentle traction sufficed to bring the placenta away, and the case went on very well. I saw both mother and child very lately, and both are in good health. I forwarded the tumor to Dr. Frederick Taylor, of Guy's Hospital, who very kindly examined it for me. The following is an extract from his letter. "A globular tumor, measuring nearly two inches in diameter. It cuts hard and dense, and presents within a great number of cysts, from the size of a pin's head to the diameter of one-third of an inch. The solid part of the tumor consists of muscular fibre-cells and white fibrous tissue; the latter in somewhat great quantity. It may, therefore, be described as a fibro-myoma undergoing cystic change, or more shortly as a fibro-cystic polypus."

The Mischievous Effect which may Arise from the Listerian Precautions in Abdominal Section.

Lawson Tait, F.R.C.S., relates the following case in the *Medical Times and Gazette*, July 31, 1880:—

H. H., aged twenty-four, sent to me by Dr. Allen, of Dudley, was admitted to the hospital, on June 21st, with a large tumor occupying the right half of the abdomen and pelvis. It moved very freely, was the seat of great pain, and had been increasing rapidly. The diagnosis was that of a tumor of the right kidney, and at a consultation it was agreed to explore, in the hope that it might be capable of removal.

On June 25th, an exploratory incision was made, the relations of the tumor ascertained to be such that it could not be removed, and the wound closed. The operation was a simple exploratory incision, of which I have performed a large number without the Listerian precautions, not only without ever losing one, but without ever having cause to be at all anxious about the recovery.

The only Listerian precaution used in this case was the carbolic spray. The strength of this spray I had been gradually reducing till now it is used of not more than 1.6 per cent. In this case very alarming symptoms set in within four hours of the operation, and within eighteen hours of the operation the abdomen was distended, the temperature rose to 105.1°, and the pulse to 160, so that I made up my mind she was going to die. It was not till the third day that distinct signs of improvement set in, and my patient appeared to be recovering.

The train of incidents were so precisely similar to those seen in a fatal case of ovariotomy, where death seemed due solely to thymol, that I at once instituted inquiries as to the possibility of some overdose of carbolic acid, and then it was discovered by the sister in charge, that a mistake had been made in the bottle from which the spray mixture was taken, and that a very strong spray had been used—what strength is not accurately known, but probably five per cent.

That the alarming symptoms were due to acute peritonitis, due to the spray, is certain from the suddenness of their onset: and the only parallel in the whole of my experience is in the thymol case alluded to. When an abdominal operation is doing badly, the distention, temperature, and pulse-rise are not apparent, as a rule, till about fifty hours after the operation; never, in my experience, have they occurred under thirty hours, save in these two instances.

I have now abandoned all the Listerian precautions but the spray, and I need not say that this incident has not made my respect for it any greater. I cannot speak authoritatively about the Listerian method in any department of surgery but my own, but in abdominal surgery it is an undoubted source of danger.

Dislocation at the Wrist.

The fact that dislocations at the wrist are extremely rare, has led Dr. E. J. Kempf, of Ferdinand, Ind., to report the following case from the note-book of the late Prof. Kempf, in the *Medical Herald*, for July, 1880:—

In March, 1851, I was walking along Shelby Street, in Louisville, toward my office, when I noticed a crowd of excited people at the corner of Green and Shelby. On investigation I found that a young man had fallen from a butcher-wagon and was severely hurt. On examining the young man I found that either both his wrists had been dislocated, or both presented a fracture. Being fresh from the lectures of Prof. Gross, the following flashed through my mind: "Gentlemen, be sure that you are right, then bulge on, regardless where you are and regardless of the ignorance of professional brethren, or of the laity's opposing you." Knowing that if the case was one of dislocation, prompt action was necessary, and as time would not allow me to send for counsel. I based my diagnosis on the following facts: The boy had fallen from the wagon directly on to both hands; the upper end of the carpus formed a prominence on the dorsum of the wrist, and the lower end of the radius and ulna projected on the palmar surface. The forearm had, so to speak, a swollen prominence on the dorsal side and a hard prominence on the palmar. I could detect no crepitus, and the wrist joint was immovable. I directed a strong man to pull at the forearm toward the shoulder joint while I made traction on the hand with all the force of my right hand, manipulating the wrist joint with my left hand. I then reduced both dislocations, the reduction of the dislocation confirming my diagnosis. The young man was directed not to use his hands in the least, to carry them in a sling, and to bathe them with chamomile tea two or three times daily. Five days after the accident the young man could use his hands, only a slight stiffness and soreness remaining.

Detection of Strychnia in Exhumed Bodies.

How long after death strychnia may be detected in the body, is a question which Prof. Ranke has set himself to discover by a series of experiments on dogs of various sizes and species, to which he administered one decigram of nitrate of strychnia. The London *Medical Record* summarizes his conclusions respecting the possibility of detecting strychnia in dead bodies. They are as follows: 1st. It was not possible to prove the existence of the poison by a chemical test in a dog which had been poisoned by the dose mentioned above (and which would prove fatal to a human being) after it had been buried 100, 130, 200, and 230 days. 2d. The presence of the poison could, however, be suspected from the peculiarly bitter taste of extracts of dogs which had been buried in the earth for 330 days. 3d. The physiological test for strychnia is much more delicate than the chemical test. Frogs, under the skin of whose backs a cold water solution of the extract had been injected, exhibited violent tetanic symptoms a short time afterward. The effects of the poison were especially strong if the extracts were taken from animals that had been buried only 100 days, but even after remaining in the earth for 330 days the extracts would produce the symptoms of strychnia poisoning in frogs. 4th. The physiological reaction is the same whether the bodies have remained in a moist or in a dry soil. 5th. Extracts which have been prepared from bodies that are far advanced in putrefaction produce a peculiar effect on frogs. They seem to become prostrate and stupefied, and the action of the heart is rendered much more feeble and slow. This is often apt to partially cover and retard the action of the strychnia. This effect is most striking when the extract is prepared from the bowels, less so when it is made from the stomach, and least when the extracts are prepared from the liver and spleen. 6th. The physiological action of strychnia is most distinctly seen when the extracts are prepared from the liver and spleen. This is not a new discovery, in so far that it has been long known that in cases of strychnia poisoning traces of the poison could be discovered in these organs *par excellence*.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Among the articles contained in the *Atlantic Monthly*, for September, are a continuation of the "Stillwater Tragedy," by Thomas Bailey Aldrich; "Two Score and Ten" (Poem), by J. T. Trowbridge; "Sir Walter Scott," by Thomas Sergeant Perry; "Political Responsibility of the Individual," by R. R. Bowker; "The Perpetuity of Song" (Poem), by James T. Fields; "Aux Serieux," by Ellen W. Olney; "Unaware" (Poem), by Maurice Thompson; "Women in Organization," by Kate Gannett Wells; "Mrs. McWilliams and the Lightning," by Mark Twain; and several others.

——*The United Service* for September contains the following articles: "Gustavus Adolphus," by J. Watts de Peyster, Brevet Major-General, S.N.Y.; "The Progress of Torpedo Warfare," by Lieutenant-Commander F. M. Barber, U.S.N.; "Benedict Arnold at Saratoga," by Isaac N. Arnold; Historical Types of Ships;" "Bits of Army Etymology," by Brevet Lieutenant Colonel W. W. Closson, U.S.A.; Man-of-war's Life Two Hundred Years Ago," by Medical Director E. Shippen, U.S.N.; "The Navy and How to Im-

prove it," by a Naval Officer; "Military Consolidation of the Indians," by Capt. H. C. Cushing, Fourth U.S. Artillery; "Cook's Naval Ordnance and Gunnery," by Prof. John M. Brooke, Virginia Military Institute; Editorial Notes, and Service Literature.

——*Lippincott's Magazine* for September opens with an agreeable and well-illustrated paper on the lake region of Florida, "Ekoniah Scrub," which, lying out of the line of ordinary travel, is but little known, though its natural features and scattered settlements are curious and interesting. The concluding paper of A. H. Siegfried's "Canoeing on the High Mississippi" describes the return voyage. "A Villeggiatura in Asisi," by the author of "Signor Monaldini's Niece," is a charmingly written account of a summer passed in a quaint Italian town, the resort of pilgrims from every quarter, and the scene of some of the most striking ceremonies and religious practices which have descended from mediæval times. "Newport a Hundred Years Ago," by Frances Pierrepont North, is an article which calls up vividly the period when this chief among American watering-places was occupied by a French army and fleet sent to aid the cause of American Independence, and was even more gay and brilliant than it is at the present day. "Horse-Racing in France," the first of two papers by L. Lejeune, is full of details that show a familiarity with the subject in all its relations. The fifth chapter of "Studies in the Slums," by Helen Campbell, treats of "Diet and its Doings." "Short Studies in the Picturesque," by William Sloane Kennedy, exhibits a close observation of the choice but characteristic features of American scenery. The continuation of "Adam and Eve," several short stories and poems, the "Monthly Gossip," which is unusually full, and the "Literature of the Day," complete the number.

OUR EXCHANGES.

Harper's Monthly for August, just received, is an exceedingly attractive number. It is difficult to designate any especially attractive article, all are so good, and the illustrations *exquisite*. The new serial, "Washington Square," by Henry James, Jr., has begun well, and promises to be of no common interest. Longfellow's poem, "Robert Burns," with its charming medallion likeness of Scotland's favorite young poet, is *the* attraction of this number.

The mid-summer number of *Scribner's Monthly* is one of especially varied interest, containing more than its usual number of articles of solid reading, the continuation of "Grandissimes," and "Peter the Great," all beautifully illustrated. It certainly is a rare specimen of an excellent family magazine.

St. Nicholas, the children's favorite, is full of bright and beautiful things attractive to others than the young folks.

Of our weekly exchanges, *Littell's Living Age* comes first and best. It cannot be excelled, and only needs to be known to be appreciated, and where the monthlies are not taken can supply their place abundantly.

Harper's Weekly is the best of all illustrated weeklies, and *Harper's Young People*, is constantly increasing in interest.

The Agriculturist is the cheapest and best of its kind, almost a necessity to every one engaged, even moderately, in agricultural pursuits.

The best of family newspapers are the Germantown *Telegraph*, *Vermont Journal*, Cincinnati *Gazette*, and Trenton *Gazette*.

Of religious weeklies, the New York *Evangelist*; *The Independent*; the Pittsburgh *Banner*; *Presbyterian*; *Christian Advocate and Zion's Herald* come regularly, and are always welcome.

BOOK NOTICES.

A Pharmacopœia, including the Outlines of Materia Medica and Therapeutics, for the Use of Practitioners and Students of Veterinary Medicine. By Richard V. Tuson, Fellow of the Institute of Chemistry; Professor of Chemistry, Materia Medica, and Toxicology at the Royal Veterinary College; formerly Lecturer on Chemistry at the Charing Cross Hospital. Third Edition. Philadelphia, Presley Blakiston, 1012 Walnut Street, 1880. Cloth, 8vo, pp. 358. Price $2.00.

In this work are found, arranged in alphabetical order, all the remedial agents used in veterinary medicine. They are treated of under the following heads: Latin pharmaceutical name; English pharmaceutical name; synonyms; natural order; composition; mode of preparation; characters and tests; actions and uses; doses; modes of application; incompatibles; antidotes; preparations. The doses are given for horses, for cattle, sheep and dogs.

The work appears to be very complete, is gotten up in first-class style, and has an index appended. It cannot fail to prove of the greatest value to practitioners of veterinary medicine.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

EFFORTS TO OBTAIN MEDICAL STATISTICS.

The worth of Statistical Medicine seems but little appreciated in this country, if we may judge from the indifference with which it is treated by the government of most of the States. It is, indeed, a modern science, and may be said to be in its infancy. The same is true of most statistical studies. This year, for the first time in our history, we are promised a census which will be something more than a mere enumeration of individuals. To be sure, the last census, made under the same efficient auspices as the present one, attempted to include economical statistics; but the results, though useful, were far from accurate or full.

As they were, they were highly valued by thoughtful men. In this year also we are promised a much better series of statistics from the National Board of Health. It has done its best, up to the present, but confessedly, that best was not good. The prime causes are the indifference of the medical profession in aiding the reporters and the confusion which exists in the forms used. Now it is stated in one of the Board's *Bulletins* that not only is there no uniform plan as to nomenclature, classification, or arrangement, but a most ingenious diversity exists as to the selection or omission of the several items of information usually expected in such reports. As most of them do not enter upon *vital* statistics, they can be compared only as reports of *mortality*, and even with this restriction it is found that of the various fundamental facts required in these reports, the total number of deaths for the year is the *single one* that can be carried without interruption through the series. The population, which is the essential basis of all estimates, is given in all the reports, but in some of them it is taken from a census too old to be of any present value in this country, where the movement of population has not only its general onward course, but its eddies and currents, due to local or temporary causes, which produce sudden and irregular changes.

The primary facts with which Statistical Medicine concerns itself, are births, deaths, marriages and epidemics. Its application to pathology, as advocated by Louis, does not properly come within its domain. On the other hand, its utility would be vastly increased could it be extended to all diseased conditions, and a general registration of disease, on some uniform, well matured plan, be effected. This has been long advocated, but not yet matured, in foreign countries.

A certain amount of discredit has attached to statistics from the facility with which they can be "manipulated." The popular impression is that they can be twisted to support any theory.

The real difficulty is that their reduction and appreciation can only be carried out by difficult mathematical methods, and by a recognition of all the factors, whereas superficial writers and critics, unacquainted with these methods, often apply others, far from correct. For example, the doctrine of averages and the calculation of probabilities are well defined mathematical branches, but by no means easy to the tyro in arithmetic. It is a strange and often startling doctrine, even to many intelligent people, that

what is true of the whole is never true of the part; that is, that the law of the average is never the law of the individual.

They say, if these results are no guides for you and me, or anybody else, of what good are they? They forget, that the rules for dealing with masses are and must be radically different from those for dealing with individuals.

The foundation of any general system of State or National Sanitation must be Statistical Medicine. Whoever wishes to aid in the work which the Census Bureau and the National State Boards of Health are interested in, should in the first instance endeavor to assist them in their collection of statistics. Last year the Superintendent of the Census made a special appeal to physicians all over the country to keep and send him certain records, blanks for which he furnished. It is earnestly to be hoped that he will not be disappointed in the amount of information he will receive from this source. So far as we know, it is the first attempt made to get these facts from all parts of our nation; that it is not obligatory, as it is in some countries, should make the profession all the more prompt to respond.

Notes and Comments.

Therapeutical Notes.

SALICYLATE OF SODA IN PETECHIAL TYPHUS.

According to Dr. Gregorianz, in *La Presse Médicale Belge*, the effect of this salt is very favorable; it lessens the tendency to delirium, lowers the temperature, and prevents renal complications. The progress of the disease also is influenced—it develops more rapidly, and convalescence is hastened. An inconvenience is its depressing effect on the heart, but this may be obviated by giving it in small doses (5 grams), and adding a stimulant, such as sherry or brandy, to the mixture.

PILOCARPINE IN URÆMIC CONVULSIONS.

Leven, in *La Presse Médicale Belge*, advocates the use of subcutaneous injections of pilocarpine in uræmic convulsions. A young girl, affected with albuminuria, was seized with convulsions with complete anuria. Two injections of hydrochlorate of pilocarpine had no effect, but at the third the remedy produced its ordinary effect. The patient, who was comatose, gradually came to herself; at the same time profuse perspiration and abundant salivation were produced. After a fourth injection the convulsions ceased and the patient recovered. The temperature oscillated between 37° and 38° C. (98⅗°–100⅘° Fah.). The saliva contained ten per cent. of albumen.

EUCALYPTUS SPRAY IN PHARYNGEAL DIPHTHERIA.

Dr. Mester, according to *Berlin Klin. Wochen.*, employs from six to sixty drops of the following solution for each spray inhalation:—Essential oil of eucalyptus leaves, 5 grams; rectified spirits of wine, 25 grams; water, 170 grams. Previous to inhalation the mixture should be shaken. Where the inhalation has to be repeated hourly, the solution must be diluted. The odor being agreeable, does not cause headache, in this respect being superior to turpentine or carbolic acid.

Generalized Vaccinal Eruptions.

Dr. Hervieux, of the Paris Maternité, terminates a paper contributed to the *Archives de Tocologie*, for June, with the following conclusions:—

1st. There exist two varieties of supernumerary vaccinal eruptions. One of these results from accidental inoculation produced by the nails of the subject or by inadvertent punctures. The other is spontaneous, and pursues the same course as an eruptive fever. 2d. Spontaneous, vaccinal eruptions are observed under a form identically similar to those of vaccinia, and are developed at the same time as the pustules which appear at the place of inoculation, or they take on the form of erythematous, papular, miliary, or vesicular exanthemata, appearing from the eighth to the eleventh day. 3d. Generalized vaccinal eruptions have often been mistaken for variolous affections. But while there can be no doubt, in spite of a widespread popular prejudice, that vaccinia does not engender variola, that is no reason that these should not complicate each other. The possibility may even be conceived, during the prevalence of an epidemic, not only of a parallel evolution of the two exanthems, but of the transmission of variola, if not by vaccinia, at least by the vaccinator, in the case of his having employed the vehicle of contagium after having been in direct relation with the subjects of variola. It is within these proportions, to be conformable to truth, that the belief ought to be confined which we are constantly coming in contact with in practice—that vaccine may become an agent of the propagation of variola.

The Action of Quinine, Digitaline and Atropine.

The following conclusions arrived at on this subject by Dr. Guido Cavazzani are published in the *Annali di Med. Pub.*, etc.:—

Quinine and atropine have an astringent action on the peripheral vascular extremities. They correct the vascular dilatation caused by digitalis. Atropine and digitaline are antagonistic, the first giving tone to the terminal vessels and paralyzing the heart, the second producing an opposite effect. These two remedies associated cause considerable slowing of the ventricular contractions of the heart, and much less slowing of the auricular contractions. Quinine and digitaline combined reciprocally increase their force of action. Quinine and atropine neutralize each other as to their action on the heart. These three remedies given singly may cause a state of collapse, which in quinine is due to ischæmia of the heart, in digitalis to its tetanization, and in atropine to its asthenia.

A New Mode of Treating Phymosis.

Hue, in *Bull. de la Société de Chirurgie de Paris*, tome iv. No. 8, suggests a plan which does away with the necessity for chloroform, and is less painful than the ordinary modes of procedure. He threads a needle with a thread of India-rubber (which may be easily got from an elastic brace), covers the point of the needle with a small piece of soft wax, and so insinuates it between the glans and prepuce as far as he desires to divide the latter. He then pushes the needle through the prepuce, and so pulls the thread through. He now stretches the India rubber at both ends, and secures it in this stretched condition by tying a thread of silk round. In ten days the elastic ligature has cut its way out, and in from ten to twenty more the wound has become healed. In about seventy cases he was satisfied with the final result. Huerteloup, commenting on this, regards the procedure as better suited for children with a short prepuce than in cases of phymosis of inflammatory origin, or where the foreskin is long.

The Efficacy of Whipping in Hysteria.

M. Ad. Henrot relates, in the *Union Médicale et Scientifique du Nord-est*, of 31st December, 1879, the case of a young female of twelve years, who was attacked suddenly, without known cause, by convulsive fits, with suffocation, cough, barking, and œsophageal spasm. The fits were very frequent, and had shown themselves twelve days before M. A. Henrot saw the patient. Physiognomy was excellent, and there was nothing in the general state to indicate a serious disturbance of the nervous system. All the antispasmodic remedies had been tried without result, so that M. Henrot thought she deserved a more energetic treatment, which he had seen successful in similar circumstances. At the first fit occurring in his presence, M. Henrot beat the patient unmercifully with a napkin previously dipped in cold water. The fit ceased rapidly, and since then the nervous manifestations have entirely disappeared.

Acute Poisoning by Iodide of Potassium.

M. Auger reports, in the *Praticien*, a case under his care in the Tenon hospital, in which the administration of two grams (thirty grains) of iodide of potassium brought on a condition characterized by fever, considerable tumefaction of the eyelids, lips, and gums, and profuse sweats. All these symptoms disappeared when the iodide was withheld.

This reminds us of a case which occurred in our own practice about three years ago, in which the patient's eyes were completely closed, and the entire face much swollen a few hours after a single dose of five grains of iodide of potassium had been taken. The swelling, together with other unpleasant symptoms, soon subsided.

Tuberculosis of the Heart.

Herr Sanger publishes in the *Archiv des Heilkunde*, Band xix, a paper, in which he reports twenty-two cases of this disease. According to his experience, cardiac tuberculosis shows itself under several forms: extra-pericardial tuberculosis, which successively reaches the pericardium and the myocardium by propagation; peri-myocardiac tuberculosis; and endocardiac tuberculosis. In these different forms, tuberculosis shows itself under the various aspects of circumscribed tuberculosis, diffused tuberculosis, and myocarditis with tuberculosis.

The Action of Collodion on Temperature.

We learn from the *Bull. Générale de Therap.*, June 15th, 1880, that Dr. Raducan has made some interesting observations on the effect produced on the general temperature by the external application of collodion; these he publishes in his inaugural thesis (*Thèse de Paris*, 1879). In health the effect on the central temperature varies with the site of the application. If the collodion be spread on either of the lower limbs the temperature is unaffected. But if the collo-

dion be applied in such a way as to cover all the cutaneous surface corresponding either to the peritoneum or the pleuræ, an immediate and notable lowering of the central temperature is observed. Dr. Raducan thinks that the difference noted explains the therapeutic action of collodion in inflammation.

Scrotal Tumors.

These tumors, which are very common in lower Bengal, although they do not often occur in other parts of India, consist in a true hypertrophy of all the scrotal tissues. They are most frequently met with in otherwise healthy individuals with an abundance of adipose tissue, and, unless removed, will grow to an enormous size. One of the largest tumors of this class was removed from a Calcutta merchant, on the 10th of November, 1879, by Dr. S. B. Partridge, late Professor of Surgery in the Calcutta Medical College, the case being reported in the *Medical Times and Gazette*, June 19th, 1880. The patient was carefully weighed before being operated on, his weight being 276 pounds; the tumor after removal proved to be 111½ pounds; so that, without making allowance for the contents of the hydrocele, etc., the mass removed fell but little short of half his original weight. When he was standing in the erect posture the tumor reached to within six inches of the ground, and he made use of it as a writing desk.

Some slight excoriations on the surface he attributed to rats having gnawed the growth on one occasion while he was asleep—an explanation supported by the fact that the sensibility of the hypertrophied integument was considerably diminished.

In the removal of these tumors, care must be taken to remove all the integument, even of the penis, as they will otherwise return. A new scrotum is always formed in from two to three months.

The Treatment of Boils of the External Meatus of the Ear.

Dr. Weber-Liel recommends, in *Deutsche Medicinische Wochenschrift*, 10th April, 1880, in boils of the external meatus, subcutaneous injections of a five per cent. solution of carbolic acid. Two to four drops of this are to be injected by one or more punctures, the point of the injecting syringe being inserted into the swollen part to a depth of one or two millimetres. When these injections are performed in the early stages, before formation of pus has taken place, the further development of the local inflammation is, according to the author, prevented. In quite the early stage a single injection often suffices, followed by ear-baths of rectified spirit containing a minute quantity of corrosive sublimate. When the boil is more advanced, several injections, either at one sitting or at different times, may be required to produce local anæsthesia of the parts. The author cautions against the use of an impure solution of carbolic acid, or of a larger quantity than from two to four drops at the commencement. If this fails to produce complete anæsthesia, the injection may be repeated the same evening, with the addition of three drops of the fluid.

Incoercible Vomiting in Pregnancy.

Dr. Welponer states, in the *Wien Med. Woch.*, May 22d, 1880, that in consequence of a recommendation of Prof. Braun-Fernwald, who has several times found it useful in private practice, he has met with excellent success, in three cases of obstinate vomiting in pregnancy which had resisted all other means, from the application of a ten per cent. solution of nitrate of silver to the vaginal portion of the cervix uteri. He keeps the solution in contact for five minutes, and then dries the parts with cotton-wool. The application requires to be repeated several times at intervals of two or three days; but its ultimate success is remarkable.

The Treatment of Ozæna.

In a patient affected with a muco-purulent fetid nasal discharge for a year, Dr. Wolfrau, according to *Berl. Klin. Wochen.*, employed, twice a day, aspirations for five minutes at a time, of a solution of tannin and glycerine, two per cent., preceded by irrigation of the nasal fossæ with a litre of a solution of sea salt. After a fortnight he had recourse to a solution of acetate of alumina, at first of one-half per cent., and then one per cent. The nasal secretion diminished in abundance and fetidity; then the number of douches and nasal inhalations was reduced. After six weeks the patient was cured of his ozæna, which had not reappeared in two years.

Anti-Vaccinationists.

The *Pacific Medical and Surgical Journal* refers those who regard vaccination as "a relic of barbarism" to the medical statistics of India, where, in three of the local governments, the total deaths from smallpox in the year 1878 were 226,946, and advises the anti-vaccinationists to

travel off to the Punjaub, where they may enjoy the fruits of exemption from the Jennerian curse. Civilization and humanity can well dispense with their reformatory services.

Correspondence.

Proposed Memorial to Prof. Bernard.

Ed. Med. and Surg. Reporter.

Having been selected by the Paris Committee (Messrs. Ranvier and Dumontpallier) having charge of the subscription for a monument or memorial to the late Prof. Claude Bernard, to represent them in the United States, I beg leave to be allowed to use your columns for the purpose of appealing to the members of the medical profession and all others interested, to subscribe to this worthy project.

I need hardly remind your readers of the great debt which every practicing physician owes to the labors of the illustrious physiologist whose memory we are asked to honor in this way.

All inquiries and subscriptions, in the shape of bank checks or postal money orders, should be addressed to me.

Trusting that I shall have the advantage of your active personal support in this matter, I remain, yours, etc. E. C. Seguin, m.d.

New York, 41 *West 20th St.*, *July* 31*st*, 1880.

Making Batteries.

Ed. Med. and Surg. Reporter.

Without the least idea of disparaging the very interesting article by Dr. Blackwood, in No. 5, Vol. xliii, of the Reporter, let me give you my plan for making a galvanic battery. Quinine bottles are pretty good for cups, but they are not so easily worked as are tumblers. I will make one cup or jar with a tall glass tumbler; you can make as many more as you wish.

Get a piece of sheet copper, four inches long and one inch wide. With a pair of shears cut *nearly off* an eighth of an inch from the edge of the copper plate. Bend this thin strip at right angles from the point it attaches to the plate. Now coil the plate around your knife handle, just as you would wind a bandage around your finger. This coil, like a watch spring, will lie in the bottom of the tumbler, on its edge, the narrow strip you have almost severed standing up and above the rim of the tumbler.

Now, if you cannot get or do not want the help of a brass founder to make you a zinc disk, three-fourths of an inch thick and an inch and a half in diameter, proceed in this way: Get some moulding sand, or clay, or plaster-of-Paris, and, with the bottom of a two-ounce bottle make a print in the sand, three-fourths of an inch deep. Melt up old zinc and pour into the print. To the centre or edge of the zinc disk solder on three inches of insulated copper wire. Bend the lower portion of the wire so the zinc disk can be hung on a stick across the top of the tumbler or on its edge. See that there is a space of an inch or more between the copper coil in the bottom and the under side of the suspended zinc disk. Put a tablespoonful of sulphate of copper on and around the copper coil, and fill the tumbler to the top of the zinc with water. Connect the wire from the zinc to the copper strip of the second jar by means of a paper fastener, or tie with a string. Make as many of these jars as you want, and your battery is complete.

In a few days the cups will contain two solutions, sulphate of copper at the bottom and sulphate of zinc at the top. Add sufficient sulphate of copper, from time to time, to keep the blue line above the copper coil, or midway between the copper and zinc. The zinc disks will need washing occasionally. The copper coils will remain good for months.

A pliable conducting cord can be permanently fastened to the copper of the first cup, and any number of cups can be used simply by putting the metallic end of the other pliable cord into the solution of the last cup of the required number.

Canyonville, Oregon. C. H. Merrick, m.d.

A Complicated Diagnosis.

Ed. Med. and Surg. Reporter.

Below is a synopsis of the diagnosis of disease made in a case by a so-called doctor of "root and yarb" proclivities in this county. The following diseases were found to exist at once, in the system of the unfortunate patient, who, it is needless to state, succumbed to the inevitable. She was afflicted (according to the "doctor's" statement) as follows: with purpura hemorrhagica, periuterine cellulitis, metritis, endometritis, peritonitis and pneumonitis combined with jaundice. "After life's fitful fever she sleeps well." Now, many of the practitioners in this locality, fearing this is contagious, would like to know if any specific remedy has been discovered for treatment of this disease. Also, if you cannot suggest some less formidable title by which we may "handle the critter," when we are forced to announce the terrible malady to our patients.

Winterset, Iowa. Anon.

News and Miscellany.

Warning to Travelers on the Continent of Europe.

A correspondent to the *British Medical Journal* describes a severe outbreak of typhoid fever in Switzerland, to be traced, it is stated, as most of such outbreaks are traced, to impure drinking water. Sir Henry Thompson, adverting to this abundant source of danger to travelers, recently recommended that every traveler should carry with him a filter and a teapot, by way of practically abolishing by personal care some of the danger of impure water by securing that it should be very thoroughly boiled before being used. Dr. Hermann Weber, whose experience of foreign resorts is perhaps greater than that of any other English authority, has published a similar warning to travelers, and has recommended them to use Apollinaris water whenever it is to be obtained, as an undeniably pure drinking water, which would secure them from these dangers; and he has stated that he

has known, in more than one instance, when members of the same traveling party have been careful to adopt this precaution, while others have neglected it, that those who adopted such precautions have been saved from typhoid fever, which attacked other members of the party. In the meanwhile, some such precaution for obtaining drinking water of absolute and guaranteed purity must recommend itself as a necessary means of safety. Recent analysis by chemical authorities, of which some of the results are before us, have shown that the water contained in the syphons which are introduced at foreign *restaurants* is not more reliable than the ordinary water supply; indeed, a table before us indicates that, in one great foreign city at least, the water in the syphons is very much more impure than even the ordinary city drinking water, being in some cases little better than diluted sewage water. It appears that the manufacturers of these aërated waters in foreign syphons are by no means very careful from what kind of surface-wells they draw their supply, or how they purify their water; and, on the whole, the danger of drinking the aërated water of syphons is, unless the quality be definitely ascertained, greater even than that of drinking the ordinary impure water. It is quite time that foreign authorities should turn more serious attention to this subject.

Monument to Professor Broca.

A committee has been appointed by the Paris Société d'Anthropologie to collect subscriptions for the purpose of raising a monument to the memory of Broca. It consists of MM. Henri Martin, Verneuil, de Quatrefages, Menier, Leguay, Topinard, Parrot, Gavarret, Pozzi, Ploix, and Magitot. Subscriptions are received by M. Masson-Leguay, 3 Rue de la Sainte-Chapelle.

Items.

—A certificate giving the cause of death as "collary fantem," was sent in to the Board of Health recently. Investigation proved the author of the certificate to have been a graduate of Buchanan's college.

—The following are the officers elect of the American Dental Association, for the ensuing year: President, Dr. C. N. Pierce, of Philadelphia; First Vice President, W. C. Barrett, of Buffalo; Second Vice President, G. J. Freidrichs, of New Orleans; Recording Secretary, George H. Cushing, of Chicago; Corresponding Secretary, A. M. Dudley, of Salem; Treasurer, W. H. Goddard, of Louisville.

OBITUARY NOTICE.

Dr. L. V. Newton, editor of *The Druggist's Circular and Chemical Gazette*, died on July 10th, at the age of seventy-one. He was born at Griggstown, New Jersey, and spent his early life in journalistic pursuits, not graduating in medicine until he was twenty-six. Dr. Newton led for a time a somewhat roving life, practicing medicine in Philadelphia, London, Virginia, in New Orleans during the yellow fever plague in 1848, and finally coming to New York. In 1858 he became editor of *The Druggists' Circular*, then having but a small circulation. By his literary and scientific accomplishments and his business capacity, he made his paper one of the best pharmaceutical journals in the country.

OBITUARY RESOLUTIONS.

Wilson.—At a special meeting of the Medical Club, in reference to the decease of our late member and associate, Dr. Joseph F. Wilson, the following resolutions were unanimously adopted:

Resolved, That in the death of Dr. Joseph F. Wilson the Club has lost one of its oldest members and most genial companions, producing universal sadness throughout the entire profession in which he was known and loved. The Society in which he was accustomed to move and act deeply mourns his sudden taking off, and the community at large has lost a valued citizen and devoted co-laborer in the field of advancement, and a persistent worker in the path of human duties.

Resolved, That the condolence of the Club be extended to the bereaved widow and family of the deceased.

Resolved, That we attend the funeral in a body, and a copy of these resolutions be published in our local papers and the Medical and Surgical Reporter, of Philadelphia.

Wm. C. Todd, M.D.,
Jos. H. Kelly, M.D.,
H. N. Uhler, M.D., *Committee.*

McMichael.—At a special meeting of the Butler County Medical Society, June 14th, 1880, the following resolutions were adopted:—

Whereas, It has pleased Almighty God, in His infinite wisdom, to remove from our midst Dr. Josiah McMichael, one of the first organizers of the Butler County Medical Society, whose professional worth and whose generous heart we all so highly esteemed, therefore, be it

Resolved, That we deeply lament the loss of our late friend and associate, Dr. McMichael, whose constantly courteous deportment toward his professional brethren and genial companionship have endeared him to our hearts, and whose intelligence and experience in the observation of diseases has commanded our respect and esteem.

Resolved, That in his death this Society has lost a most steadfast supporter, a constant attendant at all seasons, a most thoroughly useful working member, his community one of its best and most appreciated citizens, and his patients a most generous, skillful and prompt counsellor.

Resolved, That these resolutions be placed on our records; that the Secretary furnish a copy, duly signed, to the family of the deceased, with the assurance of our deep sympathy in their bereavement; a copy for publication in the *Transactions* of the Medical Society of Pennsylvania, and a copy to one or more of the county papers.

A. M. Neyman, M.D.,
R. H. Pillow, M.D.,
S. D. Bell, M.D.,
Committee.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1227.] PHILADELPHIA, SEPTEMBER 4, 1880. [Vol. XLIII.—No. 10.

Original Department.

Communications.

IRITIS; DIAGNOSIS AND TREATMENT.

BY CHAS. A. OLIVER, M.D.,

Of Philadelphia.

Read before the Northern Medical Association, April 23d, 1880.

Mr. President and Gentlemen—My reason for bringing the subject in consideration before you this evening is, that I think it among the most important of ocular troubles: not only, that if left unchecked it nearly always terminates in either visual impairment or total blindness; but by correct appreciation of early local changes which are free to inspection, and proper interpretations of symptoms which are almost pathognomonic, we can easily render, by a well directed medical or surgical course, an almost doomed eye perfect, or of great value to its possessor.

The appreciation of these facts has induced me to systematically examine the subject with you, in hopes of arriving at some conclusion in correct diagnosis and proper treatment.

1st. Let me cursorily give you the anatomy. (The lecturer here gave a concise account of the anatomy of the organ.)

Dixon, in his work on "Diseases of the Eye,"* says; "We first meet with the word 'Iritis' in a treatise by Schmidt, of Vienna, published in 1801." This assertion must seem surprising, and we can hardly believe that a disease so prominent in its symptoms should be scarcely recognized or described until such a late date.

At various intervals the medical world has been at war in reference to the divisions of the disease, some classifying the different forms according to seemingly pathognomonic dyscrasiæ, while others assumed distinctions based upon the pathological anatomy of the organ.

For my purpose this evening, I intentionally avoid making numerous distinctions between the various allied forms of the disease, and shall merely consider them under the broad heads of traumatic and idiopathic; their age, of course, necessitating another great division—acute and chronic.

(The lecturer here read two amusing descriptions of the disease, given by two German writers, Rau and Van Ammon, as quoted by Dixon*.)

What are the symptoms of an iritis?

I can best illustrate this by the recital of a few representative cases which have recently come under my immediate notice.

H. S., aged thirty years, wheelwright, noticed, four days previous to my having seen him, a soreness of his left eye, accompanied by dread of light and profuse lachrymation; cephalalgia, more intense in the left periorbital and temporal region, keeping him awake at night. For this group of symptoms he had used some kind of eye water.

Upon inspection of his left eye, I found both conjunctival and ciliary injection; the former slightly encroaching on the corneal limbus; cornea clear; iris mobile, but rather sluggish in radiary contraction. You notice I make use of the term radiary contraction of the iris, in contradistinction to the meaningless one of pupillary dilatation. I cannot conceive of the motion of a

* "Diseases of the Eye," 1860, p. 137.

* "Diseases of the Eye," 1860, p. 139.

void, and I think it would be far better to discard the term, and give the action of the iris its true verbal signification, expressing dilatation of the pupil by radiary contraction of the iris, and contraction of the pupil by circular contraction of the iris. To continue with the case, I found the pupillary border presenting a purplish vascularized appearance, two millimetres in breadth, very marked as compared with the remaining blue color.

Instillation of atropia caused even a full radiary contraction, with the exception of a strong posterior adhesion to the nasal side, no other tags or marks being visible. His vision with that eye before the use of the drug was but slightly diminished, being $\frac{20}{xxx}$ as compared with $\frac{20}{xx}$(?) with his right eye, and a limitation of accommodative range of seven to eleven inches, as compared with seven to eighteen inches.

In October of last year I saw a patient, aged fifty-one years, a seaman, who said that his left eye had become primarily sore about the middle of August, the right eye following one week later. Had had some photophobia. No headaches whatever. Had been under medical treatment, consisting of a collyrium of atropia and the internal use of one twenty-fourth of a grain of corrosive sublimate three times daily, for three weeks. For the past week he had been treating himself by potato poultices, blisters, etc. He stoutly denied any venereal history, although by indirect questioning I succeeded in eliciting the past existence of a skin eruption, alopecia, and nocturnal rheumatism.

In both eyes the conjunctival and anterior ciliary vessels were engorged and visible. The pupillary border of the right iris was heart-shaped, long axis at 75°; and situated upon the upper outer pupillary edge there was a gummy infiltration, as delineated in the crayon sketch I have placed on the board. The pupillary rim of the left iris was horizontal oval, figure-of-eight-shaped. Irides same color and corneæ clear; vision greatly impaired.

Another patient, whom I saw but a few weeks ago, presented upon the pupillary border of his left iris an irregular gummy infiltration, occupying the entire width of the smaller circle, which was enlarged, reddened and vascularized. The temporal and frontal neuralgia of this patient was so severe as to prevent sleep.

From these three instances you will notice that the principal subjective symptoms are intolerance of light; neuralgia around the affected eye, generally nocturnal; *dimness of vision*, and often general febrile disturbance. While the objective symptoms are characterized by lachrymation; sluggish muscular action of the iris, which is dependent either upon adherent bands, thickenings, or neoplastic formations in the iris structure, and change in color, which upon careful examination, is easily discernible; but no dependence can be placed upon the degrees of the symptoms; their intensity being no measure for the gravity of the case. I have here to-night a patient who beautifully illustrates this.

You will now properly ask me some of the principal causes, in order that, having a correct idea of the effects, you may make intelligent search to determine their true character.

Among these may be enumerated six prominent classes, the first five being considered more or less of traumatic origin, while the last must be regarded as purely idiopathic.

1st. Mechanical rupture of the substance of the iris.

I have never personally seen an iris inflamed from a break in its continuity, but Mackenzie* has given cuts of several cases coming under his observation.

2d. The presence and incessant motion of a foreign body in the aqueous humor; as, for instance, a piece of iron in contact with the surface of the iris; swelling of a forming cataract; escape of a portion of the cortical substance of the lens through its capsule; or even true lenticular luxation.

These varieties are not at all rare, it being almost a weekly occurrence, at any of our large dispensaries, to see an iritis so originate.

3d. Hernia of the iris through the corneal wall.

I have distinct recollection of a case of this kind, coming under my observation about eight months ago. E. J. M., aged twenty-nine, a cloth finisher by trade, said that eighteen days previous to my having seen him he had been struck in his right eye with a piece of iron. Had experienced a great deal of periorbital pain and lachrymation, for which he had been using unguentum belladonna and an eye water. Lost sight in about two weeks' time. At his first visit I noticed he had both conjunctival and ciliary injection. The iris was prolapsed through a corneal cut at the lower outer quadrant. Cornea slightly hazed, more especially around the wound. Iris discolored. No reflex from fundus.

4th. Extension of inflammation from some other diseased portion of the eye. A fruitful source being in the improper use of collyria, acting by extension through an irritated cornea.

* 4th edition, pp. 396-7.

5th. Excessive and continued accommodative efforts; improper light; sudden variations of temperature.

6th. Dyscrasia.

I think this a good opportunity to point out to you the folly of endeavoring to fully recognize diatheses in idiopathic inflammation of the iris. At present we use the terms syphilitic, rheumatic, etc., to indicate our ideas of cause only, as we know it is almost impossible, by simple inspection, to proclaim a variety of inflammation. All we do know is, that in certain cachexiæ the workshops of assimilation—the vascular and neuritic systems—have been so modified or poisoned as to throw out bad labor, imperfect cell formation, undergoing premature death; true retrograde metamorphosis, caused by abnormal development. That the iritis of dyscrasia is most certainly a mere local expression of great blood changes cannot be doubted; the nature of which will require a future era to bring its "metres and scopes" into acquisition, to be appreciated by the physical senses; the only difference between the various forms being in the dissimilarity of the cause; the results remaining almost the same.

Stelling* says "Iritis occurs at any time of life. It often destroys the good results of an operation for cataract in the most advanced old age, and it is also observed in the newly born;" and Himley† even asserts its occurrence in fœtal life.

Early adult life furnishes the greatest number of cases, which, on account of greater exposure, is not difficult to understand.

The course the disease assumes is extremely variable, sometimes reaching the acme of inflammation in a few days, and as quickly disappearing. This I have designated to you as an acute attack; but I have seen cases presenting exceedingly slight symptoms, for months and months—even entire remissions, with occasional exacerbations. Of course, these constant sources of irritation convert an acute into the chronic type of the disease.

The sequelæ of iritis are exceedingly numerous, their nature in great measure being dependent upon the degree of intensity and duration of the primary inflammation; the most formidable being the presence of adhesions between the anterior capsule of the lens and the posterior surface of the iris, or between the posterior surface of the cornea and the anterior surface of the iris. These tags prevent proper muscular contraction, thus producing constant strain and irritation. They may even surround the entire pupillary border of the iris, leading to the most disastrous results. I shall cite you two personal instances.

N. S. (colored), aged thirty years, a gardener, gave a history as follows: Fifteen years previously both eyes were inflamed; also at various intervals since. Two weeks before I saw him his left eye had again become sore, associated with temporal and periorbital pain, mostly nocturnal, for which he had been using poultices of bread and milk.

Upon examination I found in the left eye marked conjunctival and ciliary injection; cornea diffusely hazed; pupillary space small and ovoid; long axis at 135°, the border caught below and in at the point of a corneal macule. The pupil of the right eye was slit-like, six millimetres in length, angle 105°, the border caught both above and below in maculæ corneæ. Under stimulus of light the slit was widened and narrowed. Vision with this eye was only reduced to one-fourth, while in the left eye there was but one-thirty-third vision.

In April of last year I saw a young man, aged eighteen, who for the past four years had been totally blind in his left eye, the result of a blow from a stick.

The organ afforded a fine example of pupillary occlusion. The iris degenerated, discolored and streaked with blood-bearing vessels visible to the naked eye; iris tissue bulging, leaving a funnel-like pupillary space, and causing a very shallow anterior chamber, at the bottom of which were masses of cholesterin crystals.

Another is permanent atrophy of the iris tissue, rendering it friable and sometimes almost rotten. This is also seen in the tough, tendinous degenerations found in places of previously existing gummata.

If, during the course of the attack, there has been a large hypopyon, it generally leaves a series of cloudy striations covering the two surfaces of the iris and walls of the anterior and posterior chambers.

These latter forms of sequelæ have been well exemplified in the case I have just given you; that is, the atrophic iris tissue and the masses contained in the anterior chamber (in this case the possible results of a neglected hyperæmia).

I purposely avoid speaking of complicated iritis, that is, irido-cyclitis, irido-choroiditis, etc., as it would lead you into details necessitating accurate knowledge of histological anatomy, besides frequent observance of minute symptoms

* "Treatise on the Diseases of the Eye," 1868, p. 185.
† "Krankheiten des Auges." Berlin, 1844, p. 100.

which are not accessible in a general medical practice.

The treatment I shall divide into that of the acute and chronic, which will be subdivided into topical and general.

What are the indications in the topical treatment of an acute case?

1st. If the case be caused by the presence of a foreign body, the removal of the cause. Thus, a piece of iron or steel lying in the anterior chamber, scraping and scratching the already irritated iris, should never be allowed to remain, with the vague hope of absorption.

I remember a case occurring in the public practice of a medical gentleman of this city. A laboring man had an iron chipping imbedded in the inferior nasal quadrant of the iris. The cornea and lens were clear; iris slightly thickened and irregularly mobile at the point of foreign body. I was detailed to administer an anæsthetic; but upon the man's positive refusal the physician endeavored to extract. Owing to the constant motion of the eye, the attempt was unsuccessful and the operation was deferred for a few hours. The man never returned, and I afterward learned that his eye became totally blind.

2d. If the iritis originates from prolapse, an iridectomy should be performed, by snipping off the prolapsed portion.

This case will afford a good instance: J. M., aged six, a schoolboy, applied at the clinic of Wills Eye Hospital. The child gave the following history: Twenty-four hours ago, left eye struck by a stone; wound bled at the time. Much frontal and periorbital neuralgia since. Upon examination it was found that the iris was prolapsed through a cut in the lower outer quadrant of the cornea. Slight corneal haze. Iridectomy embracing the prolapse was immediately performed, and eserine instilled. In a few days the eye became quiet and vision rose from $\frac{1}{5}$ to normal.

3d. To give the iris rest.

This is done by artificial mydriasis, paralyzing the circular muscle of the iris, which would be in constant motion in its endeavor to regulate the size of the pupil. Also lessening and contracting the blood vessels, with consequent diminution of congestion and probability of fibrinous effusion.

4th. To prevent adhesions.

This is also accomplished by mydriatics, which separate the pupillary border and lift the posterior surface of the iris off the dome of the lens.

5th. To annul neuralgia.

This is partly done by mydriasis; but if the pain be very severe, it is always advisable, in a plethoric subject, to extract blood from the temporal region, preferably by means of Heurteloup's artificial leech.

If the patient be anæmic it may be better to use hypodermic injections of atropia and morphia combined, or dry cupping.

We now come to the general treatment:—

1st. The stoppage of all extraneous conditions tending to aggravate the disease.

The patient must endeavor not to subject himself to extreme variations of heat and light. These two conditions can be guarded against by keeping within doors and the wearing of protective spectacles.

2d. Lowering pyrexia and keeping the emunctories well open.

I have found that the first of these indications can be best fulfilled by well regulated doses of quinine. For the second, calomel exhibited in small doses, say one-sixth of a grain, in combination with ten-grain doses of bicarbonate of soda every few hours, until active purgation ensues.

3d. The special treatment of the diathesis.

Attack the poison, whatever it may be—syphilis, rheumatism, or other debilitating and lowering dyscrasiæ. Rid the general system of its enemy. *Treat the cause*, meanwhile not forgetting the local remedies to which I have just referred. We must remember the old established rule, that it is not only the province of the medical man to gain his knowledge wholly from a single organ, and direct his treatment to the same; but he must study the general condition of his patient, and see if he cannot find a cause for the local change, or even a similar condition affecting another portion of the body—taking care to fully understand the variety of results produced by the same diathesis in the different viscera, and not falsely associate the difference between susceptibility and the character of the impression.

In the use of mercury, and the choice of its preparation, I have but little to say. If we meet a case showing synechia, gummata, hypopyon, effusion into the crypts of the iris, or even thickening of its tissue, it is best to administer some form of the drug. It is thought, by nearly all, that the method by inunction possesses many advantages, which from my limited experience I must heartily endorse.

The treatment of a chronic iritis during the exacerbations resolves itself into that of the acute. During the remission much may be done in the way of tonics and general alteratives. Operative

interference, as a rule, is not favorable, although I remember that at the Wills Eye Hospital, during the year 1877, Streatfield's and Passavant's operation for the removal of posterior synechia, were several times performed, with comparatively good results.

Iridectomy for papillary occlusion is of frequent occurrence, and often leaves the eye in a greatly benefited condition.

If you find an eye with almost worthless vision, tension soft, associated with ciliary tenderness, and with some ciliary sympathy of the opposite organ, it is always best to immediately enucleate the affected globe.

In order to show you the importance of sufficient knowledge on the part of the general medical man to correctly diagnose and properly treat this affection, I have compared the number of uncomplicated and complicated iritis with the total number of eye patients who have for the past several years applied at the three great special dispensaries of our city. Out of a total number of 31,988 cases, there were 1613 of iritis, and its immediate complications, or about one in twenty, or five per cent. of the total; if, of these, I tell you that many of them have been aggravated in their early stages by the general practitioner, you will not be surprised at my desire to explain what little I am capable of.

I now abjure you to learn to know when to exhibit topical remedies to an eye; not at haphazard to instill a collyrium into an inflamed eye, without most thoroughly inquiring the cause of the trouble.

981 *North Fifth Street.*

SURGICAL ACTIVITY IN THE TREATMENT OF HEAD INJURIES.

BY JOHN B. ROBERTS, M.D.,

Lecturer on Anatomy and Operative Surgery in the Philadelphia School of Anatomy.

The class of injuries to be considered is an important one in its diagnostic and therapeutic bearings. The difficulty of discriminating between the different forms of cranial fracture and estimating the relative importance of symptoms accompanying them, is only equaled by the uncertainty that envelops the treatment of these serious injuries. It may seem paradoxical to say that it is not the treatment of the fracture that is troublesome; but such is, in truth, the case; for, though we do treat the fracture, it is the difficulty of determining the best method of so doing, on account of the uncertainty of the condition of the brain beneath, that causes anxiety. Fractures of the cranial bones could be easily managed, were it not for the contained brain and nerves; hence it may almost be stated, that the surgeon pays deference to the encephalon in head injuries, and thinks little of the proper osseous lesion in itself.

It is the well known inactivity of the profession in obscure head injuries, and the tendency to depend upon expectant treatment, that has induced me to consider the subject in these columns. Romance has made us familiar with the folly of the man who was always waiting for something to turn up; and such, verily, is often the condition of that physician who waits for something to turn up after severe injuries of the skull. While he treats expectantly, his patient turns downward to the grave, when the surgeon, by prompt action, might have averted the fatal issue due to depressed or splintered bone, or secondary inflammation.

In many departments of medical science it is necessary for us to be on our guard, lest we play the part of meddlesome attendants; but here the sin is usually one of omission rather than of commission. Few have done harm in our day by too active phlebotomy in brain injury, by trephining when there was no indication for such treatment, or by incising the scalp to determine the seat and character of bone lesions; yet in my opinion many a patient has died because of the omission of such procedures as venesection, trephining, and incision over the obscure simple fracture.

It is unnecessary to discuss the accepted treatment of such cases, except to mention the bare outlines. In simple concussion or brain shock during the stage of collapse, lowering the head and very careful stimulation is eminently proper. Let every one remember, however, that concussion, as a rule, means contusion or laceration of brain substance, and that inflammatory reaction may occur as a sequel. Encephalitis, resulting from contusion, due to intracranial hemorrhage, or following splintered or depressed bone, is undoubtedly to be treated by ice locally, purgatives, bromide of potassium in full doses, opium, and perhaps mercury in small doses. Of these principles perhaps not one will be considered as occupying a position liable to assault; but let the other proceedings above mentioned be suggested in a case even admitted to be hopeless, and a cloud of doubt shadows the face of the listener.

Phlebotomy should not be employed in the collapse of concussion; but when overaction

occurs subsequently, or when inflammatory symptoms arise after fracture or contusion of the skull, venesection should not be excluded from the catalogue of remedies. A full, bounding pulse, headache, delirium and sthenic symptoms call for the abstraction of blood. It is no very unusual thing to see a surgeon allow considerable hemorrhage during operations upon the skull after fracture, because it will have a tendency, he says, to avert inflammation of the brain. True; why, then, do we so often neglect to open a vein of the arm to avert the impending cerebritis, when no traumatic hemorrhage occurs? It is because it has become unfashionable to bleed; and thus the patient is allowed to pass into a condition of active cerebral congestion. I should bleed in such conditions, and have done so, without waiting for deepening coma and stertorous respiration to foretell the damage done by the inflammatory process.

Trephining is not a serious operation in itself, but has received a bad name because it is only required in cases that are serious in their nature. The injury, fracturing the skull, is usually sufficient to cause contusion and laceration of the membranes or brain, and it is from the brain injury that the patient dies, not from the hole made by the trephine. That the operation is almost innocuous is seen by looking at the results in former times, when men were operated on repeatedly for affections in which trephining was supposed to be beneficial. If performed with care, without rupturing the membrane, there is, in my opinion, little risk from the operation; but I feel that I have seen it omitted where the patient would, in all probability, have been saved by its performance. Let a small trephine be used, as it is merely necessary to obtain an opening for the introduction of the elevator, and the patient will, at least, not die from spicules of bone irritating the membranes and setting up inflammation. This is the sequence most to be feared from the omission of trephining, since it is, to a certain extent, questionable whether depression of bone alone is sufficient to produce death. We often have the combination of symptoms called compression of the brain occurring when there exists a depressed fracture of the cranium, but it is probable that it is an intra-cranial hemorrhage that is the cause of the symptoms. The crucial incision over the point to be trephined is often recommended, but seems far inferior to the semilunar or elliptical incision, by which a flap is formed. To get sufficient room for operation and examination by a crucial incision, it must be made large; and it probably divides more vessels than the flap incision. The use of the metallic shield or plate, spoken of as a protection after trephining, is seldom if ever needed, for the opening is soon filled by a firm semi-cartilaginous deposit. It might be of service when a large portion of the skull has been removed after a severe crushing in of the cranium, but can scarcely ever be required after a simple trephining for an ordinary comminuted or depressed fracture.

The metal disk and the crucial incision seem to me to be surgical traditions, which have not sufficient intrinsic worth to be retained, though they may still be spoken of with the respect due to their antiquity.

The inactivity of the attendant is sometimes shown by a disinclination to make an exploratory incision of the scalp in cases of doubtful depression, or doubtful fracture after injuries followed by serious symptoms. This arises from the idea that a compound fracture is more dangerous than a simple one. True, especially in fractures of the limbs; but in skull fractures little difference exists in the prognosis of simple and compound fractures, provided the encephalon remains intact. Hence the conversion of a simple fracture into a compound one is of little moment if it gives opportunity to examine and treat the injury done to the brain and its membranes.

The treatment of simple and compound fractures of the skull should not be considered very different, because nearly the whole of the treatment relates to the brain rather than to the bone. There are no muscles to cause displacement and deformity, and there is no danger of non-union; hence the fracture seems trivial if considered alone. The feature of simple fractures that renders them so troublesome to the conscientious surgeon is the obscurity that surrounds them. Though injuries of the head due to great and diffused force are probably complicated with brain lesions, and hence scarcely amenable to operative treatment, it is nevertheless of moment that the surgeon have a clear perception of the degree of local injury.

It is for this reason that I so strongly advocate the practice of making the simple fracture a compound one in some cases of doubt; and of making a scalp wound at times, if the existence of a fracture is suspected, and if the treatment would be modified if its existence were positively known. A scalp wound is nothing, but concealed fracture with fragments driven into the brain means death. A scalp incision for pur-

poses of diagnosis may therefore often be made, and is frequently of infinite service in clearing up the obscurity of the lesion and aiding in suggesting the treatment to be adopted.

1118 *Arch Street.*

WHY THERE IS A PERIOD TO LIFE.

BY T. S. SOZINSKEY, M.D., PH.D.,
Of Philadelphia.

That all living things, vegetable and animal, exist but for a limited period, is a truth familiar to every one. From the most lowly plant up to man himself all are doomed to pass away, to dissolve into the elements of inorganic creation. The law is universal; an exception to it is looked for in vain. Death awaits in common everything that is possessed of life.

Now, there are doubtless very few persons to whom has not occurred the question, why do we die? It is in every respect a legitimate one to ask, and we should at least try to furnish a satisfactory, a rational answer to it. That is what I propose to do briefly in this article.

Man has been curious to know why he is mortal, from the earliest times; and he was not slow to frame explanations of the fact. Like many other things which are very difficult to find out, or to comprehend, the very difficulty of the matter led early to its elucidation, in a way. Being beyond the easy ken of students of nature, it was taken hold of by students of theology, or rather elaborators of theology. An explanation of the origin or cause of death constitutes an important item of the scriptures of most religions; and it is essentially the same in all. Man is mortal in consequence of violating the command of a supernatural power; or, in other words, in consequence of sin. Thus St. Paul says, "By one man sin entered into the world, and death by sin; and so death passed upon all men, for that all have sinned." Of course, the eating of "the forbidden fruit" by Adam is here referred to.

Passing over similar ones, I may remark of the Mosaic explanation of man's mortality, that it has been and still is satisfactory to millions of people; but even if we take it as such, we are still in the dark as to the reason why other living things die. Human transgressions have had nothing to do with the origin of the mortality of other creatures; for death prevailed among them myriads of years before man appeared on the earth. The presence of their fossilized remains in the oldest strata of the earth's crust sufficiently attests the fact. Apart from other reasons this failure of the explanation to cover the whole ground impels one to doubt its validity, even in the case of man; and, in consequence, students of nature are forced to still occupy themselves with the problem.

It may be safely asserted that the real cause of death among living things, including man, is not undiscoverable. I believe that human knowledge has advanced far enough to enable us to correctly explain it. Every-day observation, as well as common sense, teaches us that there is a reason, a cause, for the death of everything; so it must be a subject which admits of scientific elucidation. The inductive method of study brought to bear on organic creation—which an enlightened philosophy teaches us is a systematic scheme—has cleared up so many difficulties which formerly seemed insuperable, that there are substantial grounds for confidence that this one will yield to it in the fullest degree.

Why is it, then, that we die? The reason is to be found in the fact that life is conditioned. Life is possible under certain conditions and impossible under others. Heat is necessary; so is air; and so is food. Without suitable heat and air and food, or any one of these, life cannot be. While the earth was in an incandescent state life did not exist thereon; because the heat was too great to admit of it. While the atmosphere was saturated with carbonic acid only plants existed; for when this gas is present in large amount it is destructive to animal life. And plants must have existed before animals, because the latter cannot draw sustenance directly from the inorganic world. Do we not see, then, that in understanding why we live, we at the same time get a clue to the reason why we die? While life is present death is not, and *vice versa*. To die is to cease to live.

Now, life being conditioned, of course, if the necessary conditions were wanting it could not exist.

I have just spoken of some of the necessary external conditions; but there are conditions of the organism as well as of the environment, which, if wanting, life cannot exist. Thus, the blood must circulate, the lungs must act, and the nerve-centres must have free play. In man, as in every one of the higher animals, anything which stops the functional action of the heart, or of the lungs, or of the brain, results in death. In organisms in which these organs are present in rudimentary, or specially modified form, the same result follows when they are interfered with, so that their functional activity is seriously perverted, or stopped. Between the internal and the external conditions there is a sort of antagonism. Herbert Spencer lays great emphasis on this an-

tagonism; he goes so far as to regard life as "the continuous adjustment of internal relations to external relations." However, our argument leads us to the conclusion that it is inconceivable that an immortal being could exist in a world where the essential conditions of life are liable to be removed If life were entirely independent of conditions it might continue for an indefinite length of time.

But how is it that age leads to death? Simply because the conditions necessary for the continuance of life are removed thereby. And we must search for the cause within the organism. The necessary external conditions still remaining, of course, the trouble must be seated in the internal conditions. Something must occur to the organism which results in the suspension of one or more functions necessary to life; because, as the medical philosopher Broussais puts it, "for a person to die, it is necessary that the principal instruments of life should be seriously injured." Some change is produced in the organism which interferes seriously with circulatory, or respiratory, or nervous action. And here I may say that if any one of the necessary functions is affected, all others suffer in consequence. The various parts and functions are intimately related to one another; each is, in a measure, dependent on all the rest for its welfare. From these premises it follows that death from age may be caused in different ways. In one person it may result through circulatory defects, in another, through respiratory defects, and in another, through nervous defects. To be sure, all these functions may be gradually encroached upon at the same time; and I imagine that in ideal death from old age such is the case.

Most physiologists hold that death from old age begins in the nervous system, in the brain. Bichat, the French genius who laid the foundation of modern physiology, in his immortal work on life and death, elaborated this belief. He came to the conclusion that the distinguishing features of animal life are merely additions to vegetable life. He says, "The functions of the animal are of two very different classes. By the one, which is composed of an habitual succession of assimilation and excretion, it lives within itself, transforms into its proper substance the particles of other bodies, and afterwards rejects them, when they are become heterogeneous to its nature. By the other it lives, it perceives, it reflects on its sensations, it moves according to their influence, and frequently is enabled to communicate its voice, its desires and its fears, its pleasures and its pains." The aggregate of the functions of the first order he named the organic life, and the aggregate of the second, the animal life. When death is typically natural, the animal life is cut off in advance of the organic life.

Death in man and in all animals begins in the central portion of the nervous system, in the brain. Dr. B. W. Richardson, whose views on this subject are essentially the same as Bichat's, in his work on diseases of modern life, says, "The end, when it comes at the duly and fully appointed time, is, I believe, always preceded by failure of the nervous stimulus. The muscles would continue to act if they were excited and directed into action; the secretions would proceed, and in truth often do proceed, when the faculties of the mind and of volition have ceased; but the nervous organism, through its varied parts, fails, and with it die all the parts that depend upon it for animation." I believe, as already stated, that from the dependence of the various functions on one another, the actual cause of the exhaustion of nervous energy or vital force may be located elsewhere than in the nervous system.

It used to be, and is still, the belief of some, that the essential cause of death from old age is the exhaustion of an inherited stock of vital force. One of Shakspeare's characters says of his life that it

> "Bleeds away, even as a form of wax
> Resolveth from its figure 'gainst the fire."

This opinion is untenable. Whatever store of vitality a person may have is constantly being added to as well as subtracted from; and it is in no wise necessarily lessening in its totality every succeeding day; on the contrary, it may be increasing. There is a constant renewal being effected; and herein lies the element of greatest difficulty in explaining why we die; for as Bacon says, "that which may be replaced by degrees without a total waste of the first stock is potentially eternal as the vestal fire."

While life lasts there is constant change going on in every organ of the body; old particles are constantly being replaced by new ones, which in their turn are replaced by others. This molecular change goes on at varying rates of speed in different organs and at different times. Some glands are replaced entirely in a few days, while bones change but slowly. Exercise hastens molecular activity or nutritive action in all the tissues; and various medicines known as stimulants and alteratives have a similar effect. It was formerly, and is still to some extent, the popular belief that the entire composition of the body is changed once every seven years.

This nutritive activity is the fountain of life, the source of all vital phenomena; while it continues the organism is said to be alive, and when it stops, the organism is said to be dead. From the beginning to the end of life it goes on incessantly. Does it not follow that death from a gradual running out of vitality results from the gradual stoppage of this nutritive activity? The power of repair fails, and when it ceases altogether dissolution sets in. As Dr. Rush, in his admirable essay on old age, says, "death from old age is the effect of a gradual palsy."

I believe, then, that the immediate cause of death from old age is exhaustion of vital force, or rather, of the power of reproduction of vital force. Says Dr. Carpenter, in his work on physiology, "Of this diminution of formative power we have evidence in the entire absence of any attempt at new development, in the less perfect and more tedious manner in which the losses of substance occasioned by disease or injury are recovered from, and in the gradual deterioration of the organism in general. The tissues which are rendered effete by their functional activity are not any longer replaced in their normal completeness; for either the quantity of new tissue is inadequate, so that the bulk of the organism is obviously reduced, or their quality is rendered imperfect by the production of structures in various phases of degeneration, in place of those which had been previously developed in the fullest completeness. The inferiority of nervo-muscular energy and of general vigor are thus evidently the result of the deficiency, and not, as in the period of growth, of the excess of formative power; and in proportion as the waste of the tissues consequent upon their functional activity is more rapid than their renovation, a progressive loss of substance must take place. The forms of degeneration most commonly met with in advanced age are the fatty and calcareous." Why this reparative power should fail, must, I believe, be sought for in structural change. Dr. Richardson believes he has found out what this change is. He says: "I have learned that the gradual transformation of the vital organs of the body from the advance of age is due to a change in the colloidal matter which forms the organic basis of all the living tissues. In its active state this substance is combined with water, by which its activity and flexibility are maintained in whatever organ it is present—brain, nerve, muscle, eyeball, cartilage, or membrane. In course of time this combination is lessened, whereupon the vital tissues become thickened, or to use the technical term, "pectous." By attraction of cohesion the organic particles are welded more closely together, until at length the nervous matter loses its mobility and the physical inertia is complete."

But I have not yet done more than hint at the reason, or reasons why we die. I have merely stated what occurs as death approaches, namely, that the tissues become more and more condensed and somewhat changed in substance, and that the vital power is gradually lessened. Just why these changes should occur has not been explicitly stated. Dr. Richardson, in discussing the subject, comes to the conclusion that "death is part of the scheme of life—is ordained upon a natural term of life." This statement is unsatisfactory to every questioning mind. We want to know something more; we want to know the reason why life passes away? why it is limited in date. I think this information can be furnished, and that the cycle of life need not be regarded as mysterious. The philosophy of why we die may be stated in a few words. It is a well established fact that in body and mind we reflect, in a great measure, the traits of our ancestors; or, in other words, for what we are in structure and function we are largely indebted to inheritance. At birth some of us are healthy, free from taints of disease, while others are just the reverse. Our parents have bequeathed to us bodies of various degrees of soundness. Those soundest to begin with are most likely to be the last to die. Now, passing through life we are constantly subjected to a great many influences which tend to destroy the vital spark. We have to contend with the elements, heat and cold, with mental dislikes, and so on. These influences which tend to destroy life are constantly contending with our vital powers, and when the former triumphs, destroys the latter, death is, of course, the result. This may come in a few days, or in a few months, or may be postponed for a hundred years; but it is the inevitable end of the struggle in every case. Let us foster and fortify our vitality as we may, it will give out. Extreme age is simply the longest period that life can hold out against the physical forces which are constantly operating to destroy it. Changes of structure are due to vicissitudes of vital action, and these lead gradually to impairment in the power of renewal of the latter. Such is, in brief, the explanation of why we die.

2210 *Fairmount Avenue.*

—M. Verneuil, surgeon to La Pitié Hospital, and Dr. Charcot, chief physician of the Salpêtrière, have been made officers of the Legion of Honor.

Hospital Reports.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

CLINICAL LECTURE BY WM. GOODELL, M.D.,

Professor of Clinical Gynæcology in the University of Pennsylvania.

REPORTED BY WM. H. MORRISON, M.D.

Carcinoma of the Cervix Uteri.

GENTLEMEN:—The first case is that of a married lady, thirty-seven years old. She has had some five or six children and some miscarriages. A few months ago she began to lose blood and to have a discharge from the womb. She then went to her family physician, who diagnosed carcinoma. She arrived here yesterday, having come a long distance, to see if something could not be done.

On examining the womb, I found that the disease had involved the surrounding parts to a large extent. This is, unfortunately, too often the history of these cases. Women are so liable to have pains in the back and in the pelvic region, that they often pay no attention to them. By and by a hemorrhage occurs, or they have a discharge of some kind, and then they seek a physician. Just here I want to disabuse your minds of one error; that is, that cancer is accompanied with severe pain. Cancer of other organs is usually accompanied with pain, but cancer of the womb generally does not produce more pain than a retroflexion or other ordinary condition of the womb. Often it does not cause as much as a polypus of the womb. It is exceptional in my experience for a cancer to produce pain, except when it has involved the internal os and passed into the cavity of the womb. Then it usually produces great suffering. The woman pays no attention to the slight pains she has, until the appearance of blood alarms her and she seeks advice. By that time the cancer is an open sore, and little can be done for its relief, while if it had been seen earlier the physician might have been able to remove a healthy portion of the cervix, and thus stop the disease.

In this case the cervix is wholly gone posteriorly, and has gone so near to the rectum that I shall have to operate with great care in that direction, as I might possibly hasten the rupture into the rectum. Anteriorly the cervix is all gone except a small rim of tissue behind the bladder.

I told this lady, frankly, that her case was a hopeless one, except under one condition, which I have had happen to me; that is, after the operation all the diseased tissue came away with the slough. I always like to hold out some little hope to these patients. My prognosis here is very bad. All that I can do will be to prolong life.

The operation I shall perform will be to remove, by scraping, as much as possible of the diseased tissues of the neck. Here is the advantage of using one's left hand in these operations. Cancer of the womb is often very fetid, and the odor will cling to the hands for several days. I think it is dangerous to deliver a woman after having soaked one's hand in the juices from a cancer; but using my left hand here, I keep my right hand clean for other work.

I shall take these fenestrated polypus forceps, and with them I can tear away a good deal of this tissue. If you buy a pair of these forceps, I advise you to get them with the obstetrical lock. The more boldly you work the less hemorrhage you have. It is not often that I have much hemorrhage while performing this operation, but occasionally the flow of blood is profuse. I pass my forceps into the cervix, and catching the prominences, tear away as much as possible. Tearing off these fragments, I remove a bleeding and secreting surface. In this case the hemorrhage has not been great; there has been more discharge of mucus. I shall now use these gouge forceps, which have a cutting edge. I remove all until I come to the internal os.

What do I expect to gain by this operation? I expect to get a surface some portion of which will heal, and become covered with a non-secreting surface; I cannot call it a healthy surface. This will lessen the amount of discharge, and then by tearing away this tissue I release the nerves from undue pressure, and lessen pain, although that has not been a marked symptom here. I am now working toward the rectum, and I am going very carefully. I feel here a hard cartilaginous septum, dividing the cervix into two parts. I have made a hole in this cervix so large that I can introduce my four fingers into it. Introducing the Sims speculum and catching the womb with the volsella forceps, the gentlemen on the front seats can see the hole I have made.

I am not alarmed at this hemorrhage, for I know that I can pack this cervix and thus stop it, if it becomes too profuse. I have performed this operation a great many times, yet I have never had a fatal result from it. In one of the cases, as many of you are aware, while operating before you, I made a hole posteriorly directly into Douglass' pouch, but I went on and completed the operation. The woman had a slight rise of temperature the next day, or the next two days, but no more than usually follows the operation. She was able to go to her home, a long distance, in a week's time. I shall now take the curette and try to remove more of this diseased mass. Posteriorly, I have almost reached the peritoneum. There is only a thin layer of tissue between my finger and Douglass' *cul-de-sac*. I cannot pass my finger into the cavity of the womb, and so I infer that the disease has not passed above the internal os.

I have now removed a great deal of this cancerous mass. The next thing that I shall do will be to burn this thoroughly with the benzolin cautery (Paquelin's cautery). I take the cautery out once in a while, because it heats the speculum so hot that it might burn the tissues below.

I have never had secondary hemorrhage following this operation, but I have had severe hemorrhage during it. I was placed in rather an unpleasant position not long ago. I was called to the country to remove a cancer from a lady; I was assisted by the family physician and

the nurse; they were the only persons present. The hemorrhage was very great, and while my whole attention was directed to it, I noticed that the physician, who had not been very well, grew deathly pale, and I saw that he was going to faint. We had to discontinue the operation for a time, while he lay on the floor. There was a bottle of whisky on the table, which I told him to take. There was also some Monsel's solution and acid nitrate of mercury. I saw that he got the right bottle, as I could not leave to get it for him. He soon came around all right, but he did not come back to the bleeding place, but took charge of the ether, and I had to make out with the assistance of the nurse. I tell you, it made me sweat for a while, as the hemorrhage was quite alarming.

I expect that this woman will be able to return home in the course of from ten days to two weeks. After a couple of days there will be a very bad smell produced by this slough, and she will have to use permanganate of potash injections. If there is any rise of temperature I shall give her quinia. She will probably have very little pain. I ordinarily do not have to give an anodyne, but I will direct the nurse to slip into the rectum, as she comes to, a suppository containing gr. j of the aqueous extract of opium. This will relieve the pain caused by the stretching of the perineum, and the soreness in the joints caused by the position in which the limbs have been held.

Now this lady will probably feel a great deal better. She will gain flesh. Her appetite will increase, she will have less discharge, and I may have prolonged her life for a long time. I may have given her two years or more, by this operation, but I think not. I think her life will be measured only by months.

Laceration of the Cervix, Vegetations, etc.

The next is a case of metrorrhagia. What do we mean by metrorrhagia? Menorrhagia means an excessive discharge of blood at the monthlies. Metrorrhagia means a flow of blood from the womb at any time. This woman is twenty-seven years old, married, has had two children, and two miscarriages; the youngest child is two years and eight months old. Both children were delivered by instruments. This looks like some contraction of the pelvis; but it depends a great deal on the physician who attends the case, for some apply the forceps in cases of only ordinary delay.

I will tell you what I expect to find in this case. I know nothing about the case except the short history I have here. I will read the rest of it:—

She has had two hard labors, the children being delivered by the forceps. She has profuse leucorrhœa, a sharp pain in the sacrum, increased by lying on the back, and a dragging pain in the right iliac region. These symptoms have come on since the last pregnancy. Now what is their significance? Leucorrhœa is only another form of hemorrhage. In one, we have a loss of the red blood corpuscles, in the other, a loss of the albumen. Both are exhausting. She has sharp pain in the sacrum, more severe while on the back, and a dragging pain in the right iliac region. I think the sharp pains are due to a displacement of the womb backward, or perhaps to pressure on the ovary. The dragging pain also indicates some displacement. She probably has subinvolution, laceration of the cervix, and lastly, she probably has vegetations inside of the womb. Now this is what I expect to find. I do not think that there is a fibroid tumor, for Dr. Baer says nothing about it in his report. I attribute all her troubles to her confinements. I think, then, that I shall find subinvolution, laceration of the cervix, vegetations and probably retroflexion.

On examining, the first thing I notice is that the os is so large that I can introduce my finger up to the first joint. Now that certainly means something wrong. It must mean a laceration. If the axis of this cervix was prolonged it would strike the ceiling; that is, it looks upward and forward instead of looking downward. Introducing the sound, I find that it curves backward, showing that the womb is retroflexed. Now for the measurement. It measures three inches. It should not be more than 2.75 inches, in a woman who has borne children.

I am pretty sure now that I am right in my last supposition, that is, that there are vegetations in the cavity of this womb. If the sound had passed in four inches, I should have said there is most likely a fibroid tumor or a polypus. In my experience, a womb that is simply subinvoluted, rarely measures more than 3.5 inches. I shall now introduce the curette and see if I can get any vegetations. I feel a roughness posteriorly, and in the right and left cornua, but in front I feel none. I bring away a number of these vegetations. Some of them are almost large enough to be called small polypi. Last week I saw a lady who had been bleeding a great deal at her monthlies. I passed the curette and brought away a beautiful little polypus. It looked like an ear-drop, it was so perfect.

The next thing that should be done here, would be to put the womb in place, and keep it there; but it would not be right to introduce a pessary now, after having curetted the womb, and while she is suffering pain. We will leave that for another time. I will complete the operation for to-day, by making an application of tincture of iodine. This tincture is not quite a saturated one, but nearly so. I use it for two purposes: first, to destroy any vegetations that I have bruised but not entirely removed, and secondly, to prevent septicæmia from the putrefaction of those that have been left in the cavity of the womb. As to the laceration, she would be decidedly better if she had an operation performed for its cure.

What is the significance of the pain in the back? It is due to the pressure of the womb upon the nerves behind it, or possibly to its pressure upon the ovary. Now this operation of removing vegetations is best done at the patient's house, yet I am constantly doing it in my office, without any bad results.

Gentlemen, I was nearer right in my suppositions than I expected. I thought I should have blundered in some of them. I expected to find a laceration, because where a woman has

been delivered twice, or even once, instrumentally, and dates her troubles from her confinement, I generally find a laceration. I expected a retroflexion, because when the womb is subinvoluted it is heavier than natural, and generally topples backward. The reason it takes this form is, because behind we have an empty space, Douglass' pouch, while in front we have the bladder, which always contains more or less urine, and thus keeps the womb from becoming anteflexed. Anteflexion, in exceptional cases, does occur.

Laceration, Subinvolution, Retroflexion.

This case has come quite a long distance. She is very desirous of entering the hospital, but as all the free beds are occupied, it will be impossible for me to admit her, unless it is an operative case which can be cured in a couple of weeks.

She is a married woman, twenty-five years old. Her youngest child is two years old. She was well up to the birth of her last child. The labor was a hard one, but not instrumental. She complains of difficulty in passing her water. She nursed her child eighteen months.

You notice that she talks through her nose. That always awakens a suspicion in my mind of specific disease; but she says that she has had this cold in her head only two weeks, and that she has had no eruption nor a bad sore throat.

She did not see her monthlies while nursing the child, but they came on shortly after meeting with an accident. This may have been simply a coincidence, or the accident may have furnished the exciting cause for the return of her menses. She says she has a pain in her stomach, and when I ask her to put her hand on the spot, she places it over the left iliac region. This is like the Irishman, who, saying he has a bad pain in his heart, puts his hand over his stomach. We have an old English word, belly, and it would help us greatly if this word were still in use, for I have often been led astray by a woman telling me she has pain in her stomach when she really meant her belly.

I will now see what I can make out with my finger. She plainly has a laceration of the cervix and ectropion of the mucous membrane. Just as we have ectropion of the conjunctiva, so we may have ectropion of the mucous lining of the cervix. I expect, such being the case, to find this womb enlarged and probably retroflexed. I pass the sound and find that the womb is not perfectly retroflexed, but that we have a sinistro-lateral flexion. The womb measures three inches. I presume that her bladder symptoms are wholly due to the uterine troubles.

Now, as to the treatment. I shall, to-day, introduce this pessary, which is the No. 1 of Smith's modification of the Hodge pessary. You will use six of these to one of any other kind. I shall pass this in to support the womb, passing it in behind the cervix. I now measure with my finger, to see if there is room enough between the anterior bar and the pubic bone. There is a little too much room, but we will begin with this, and then, if necessary, use a larger one after a while. A pessary alone will not cure this case. I shall also give her the following—

℞. Infusi gentianæ comp., f. ℥ vj
Potassii bromidi, ℥ ij. Solve.

Sig.—A tablespoonful directly before or after meals.

I give her this, why? Bromide of potassium is one of the best so-called anodynes for pelvic irritation. It relieves ovarian and uterine congestion and irritation. By giving it in the compound infusion of gentian, I partly conceal the taste, while, at the same time, I stimulate the digestion and increase the appetite. The next thing to do will be to make weekly applications to the cavity of the womb. I will probably also put her on the use of the fluid extract of ergot and chloride of ammonium; twenty drops of the former and ten grains of the latter three times a day. The ergot will cause the womb to contract, while the chloride of ammonium stimulates the absorbents, and thus facilitate the return of the womb to its normal size.

Editorial Department.

Periscope.

Perfectly Bloodless Operation.

The "bloodless" method of operating, recommended some years ago by Esmarch, is opposed by many surgeons, on account of the general oozing which is apt to occur after removal of the elastic tube. Esmarch describes, in *Verhandl. d. Deutschen Geselsch. f. Chirurg*, for April, 1880, the latest practical modification of his mode of procedure, by means of which such oozing may be completely prevented. In amputations, the operation is performed in the usual way, by the bloodless method; all vessels requiring ligature are then carefully sought out and tied, and the wound at once closed with catgut sutures; drainage tubes, capable of being absorbed, are introduced, and Neuber's permanent compressing dressing applied. Then, and not till then, is the elastic tube removed from the limb. After the patient is placed in bed, he should keep the stump up in the vertical position for at least half an hour. (Neuber's permanent dressing consists of an antiseptic cushion, four-cornered, made of carbolized gauze filled equally and smoothly with carbolized jute; this cushion is applied directly to the wound, and is kept firmly in place by an elastic bandage which overlaps the dressing). Of twelve amputations (nine of the leg) performed and treated in this way, secondary hemorrhage occured in none; in most of them the first dressing was not removed for fourteen days, and on it was then found only a

narrow, dry streak of blood, corresponding to the linear cicatrix. In resection the author advises that after all visible ends of vessels have been tied, the wound should be closed with the continuous glover's suture, and that the limb should then be made fast to a splint and kept elevated for at least half an hour. In fifty-six resections managed in this way since 1878, neither secondary hemorrhage nor death had occurred. Since Easter, 1879, the author had also, in his operations for diseased bone, given up the practice of plugging the cavity from which the sequestrum had been removed; instead of this he now carefully disinfects the cavity, introduces absorbable drainage tubes, closes the wound in the skin at once, and applies the permanent dressing; the last step in the proceeding is, as before, the removal of the elastic tube. Twelve cases were treated in this fashion, and in none of them did secondary hemorrhage occur; in all of them the wound remained aseptic, and in several instances complete primary union took place. Esmarch also states that he has frequently adopted, and with similar results, the same method in various other operations on the extremities, such as the removal of tumors from these parts; in the neighborhood of the shoulder and hip joints, however, it is a matter of much greater difficulty to carry out the above directions, and so to obtain a perfectly bloodless operation.

Watching the Pulse During the Administration of Chloroform.

Dr. W. Munro, of Manchester, writes, as follows, to the *British Medical Journal*, August 7th, 1880:—

After many years of experience in giving chloroform, both in private practice and as a hospital surgeon, I view with some apprehension the views lately put forward by some of your correspondents, that there is no need to watch the pulse in giving chloroform, only the respiration. In inhaling it myself I observed that about a minute was occupied between the time of inhalation and the maximum effect being produced, so that if the patient's pulse begin to intermit, that time has to elapse between the time that the chloroform is taken from the mouth, *with the effects of the chloroform still deepening in intensity*. Surely, then, it is of importance to note the very faint beginning of such mischief.

I have never seen a death caused by chloroform, but I have seen a few cases in which it was necessary to stop the operation for a time, on account of the effects of the chloroform, which, in these cases, always acted firstly on the heart. In no case have I seen cessation of the respiration. The experience, however, of death by chloroform in the human subject of any one medical man is necessarily so limited, and the circumstances of such deaths are so little favorable for scientific observation, that I think it is highly dangerous to found a mode of practice on the ideas of one or two, who may be inclined to look on the cessation of respiration as the first danger to be avoided, and the only one to be carefully looked for. Perhaps, in regard to this, I may be allowed to speak from my experiments made on animals in 1875–76.

In these experiments, *inter alia*, I found that in cats, when chloroform was rapidly administered (the best way, in my opinion, as avoiding that saturation of the blood with chloroform which is apt to be produced by slow administration, and which renders stoppage of the heart's action, if it does occur, almost surely fatal) the systolic action of the heart *invariably* ceased before respiration. If the chloroform was then removed at once, it was sometimes easy enough to restore animation, but if the chloroform was continued until the respiration stopped also, the chances of recovery were infinitely reduced, and disappear when auricular action ceases. I found on post-mortem examination and experiment that chloroform invariably stopped the action of the heart when found on it.

Wishing to protect the heart's action against the chloroform, I, after several preliminary experiments, used a large, but not a lethal, dose of atropine, injected about an hour previously to the administration of the chloroform. I now found that the respiration invariably stopped before the heart's action, stoppage of the latter being exceedingly difficult to produce in one case; indeed, I could not kill the cat, though I gave it chloroform in as strong saturation as I possibly could for thirty-five minutes (two minutes being generally sufficient to kill), and recovery after stoppage of respiration was generally *spontaneous*, respiration recommencing of itself; but when I pushed the chloroform till all signs of heart movement were stopped, the effects were the same as if no atropine had been given.

Whatever opinions may be held as to the propriety of continuing the use of chloroform as an anæsthetic, it is still used by many every day, and while it continues to be so, it is of importance that all precautions for using it safely should be taken.

In conclusion, I may say that I should be glad to know that any hospital or other surgeon who still continues to use chloroform often was taking advantage of the hints to be gleaned from my experiments as to the use of atropine as a heart protector during its administration.

Abscess of the Spleen.

The following case is reported in the *Medical Record*, August 21st, 1880, by George H. Stone, M. D., Acting Assistant Surgeon, Marine Hospital Service, Savannah, Ga.:—

Frank Taylor, a native of Savannah, Georgia, aged thirty-two years, married. Has been employed for several years on the tug-boats running on the Savannah River, residing during that time on Hutchinson's Island, opposite the city. The surface of that island consists of reclaimed rice fields, and up to 1877 was overflowed at every tide. The island is one upon which no white person could live with impunity before it was drained, and very few choose to risk it now.

From September 12th to September 19th, 1878, I treated the patient for remittent fever and diarrhœa. From April 11th to April 16th, 1879, he was again under treatment for eczema

cruris. July 2d, 1879, I was called to see him, and found him suffering from remittent fever and splenitis. Acute splenitis developed, and on August 4th, 1879, his condition not having improved, he was admitted to St. Joseph's Infirmary Hospital.

On admission his temperature was 104°, pulse 120; the fever remitting in the evening. In a few days the acute febrile condition subsided, leaving behind pain over the spleen. Percussion developed immense enlargement of the spleen to the median line in front, downward almost to pelvis. General debility, with hectic flushes every day. The general prostration gradually increased until about September 10th, when I detected fluctuation. On the 14th day of September, 1879, I introduced an aspirator needle, and drew away 1000 c.c. of pus, after which the tumor subsided to half its former size. The aspiration was repeated on the 21st and 29th with a like result.

On the 10th of October, after inducing anæsthesia with chloroform, I made an incision just above the crest of the ilium, where the pus seemed to point, and evacuated 250 c.c. of pus. The abscess continued to discharge until his death, November 14th, 1879. At the post-mortem examination (which was only partial, on account of decided opposition of his friends) the abdomen was opened, and the viscera were found healthy, with the exception of the spleen, which organ had been entirely absorbed, except the capsule, which formed the sac of the abscess and enclosed the pus.

The Operative and After Treatment of Amputation of the Supra-vaginal Uterus, in Fibroma.

Dr. Dorff, Assistant Physician to the Gynæcological Clinique in Freiburg, gives, in No. 12, *Centralblatt für Gynakologie*, 1880, an account of eight cases in succession in which, by Hegar or by Kaltenbach, the uterus had been removed on account of fibroid tumors, all of which were successful, and all had been treated since August, 1879. The author objects to Pean's extra-peritoneal method, as hitherto practiced, on two grounds: first, that it is usually not, or at least not completely, extra-peritoneal. Only when the cervix is very mobile or very long does it permit of being so far drawn out as that the ligatures lie in front of the abdominal wall. In other cases they lie between the edges of the abdominal incision, and even in the peritoneal cavity, beneath the serous membrane. The second objection to the Pean method is the usually rapid onset of decomposition in the stump, and the great difficulty in keeping it antiseptic. To avoid the first difficulty, Hegar stitches the peritoneum close to the stump below the ligatured point, so that the stump comes to project free from the bottom of a short conical or funnel-shaped cavity, the sides of which are formed by the thickness of the abdominal wall, and communication with the peritoneal cavity is completely shut off. To avoid sepsis in the stump, Hegar, partly by experiment on animals, partly by observation of operation cases, has arrived at the result that the stump can only be kept securely aseptic by dryness and keeping away of every kind of moisture. This end is effected in these operations, firstly, by the most careful arrest of bleeding in the abdominal incision; secondly, the stump itself, on its cut surface and on its peripheral aspect, is cauterized as deeply as possible with Paquelin's cautery. Then the edge of the abdominal incision on the lateral walls of the funnel-shaped cavity is painted over with a ten per cent. solution of chloride of zinc, the excess of solution being carefully dried up, immediately after the painting, with small balls of cotton wool. The bottom of the funnel is avoided in this process, and a weaker solution employed for it. Small rolls of absorbent wool, which have been steeped in a weak chloride of zinc solution (1–2 per cent.) and then dried, are pushed between the stump and the edge of the wound, and the cavity thus carefully filled. The rest of the dressing must be so arranged that one may examine the stump and surroundings at any time without disturbing the dressing. If the rolls of cotton wool are moistened with blood or wound fluid, we may be sure that decomposition is setting in rapidly. The unpleasantness in this treatment is the sloughing off of the edges of the abdominal wound and its surroundings. This slough begins to come away from the sixth to the seventh day. Hegar and Kaltenbach have not seen any bad results from it. After the fifth or sixth day the chief dangers are over. These operators do not now employ Pean's ligature, but the elastic ligatures recommended by Kleeberg, in Odessa, for fibroma operations. A short account of the eight cases is then given.

Cataract Extraction.

Dr. Borysiekiewicz, in *Klin. Monatsbl. f. Augenh.*, for June, 1880, gives the result of five years' experience of cataract operation as assistant in Professor Stellwag's clinic at Vienna. The object of his paper is to point out the relative value of two different incisions which were employed in about an equal number of cases. Of the three hundred and sixty-five cases of senile cataract in which the operation was satisfactorily performed, one hundred and eighty-four were extracted by means of what he calls the "modified corneal flap incision." In this incision the puncture and counter-puncture are made 1 mm. above the horizontal diameter of the cornea, at a distance of 1 mm. from its edge, while the middle of the wound is allowed to fall within the cornea by turning the edge of the knife forward. The remaining one hundred and eighty-one were extracted through a "sclero-corneal flap incision" with a conjunctival flap. In all cases the incision was made upward, and the eye fixed by means of forceps. Chloroform was administered in seven cases. The patients were always visited within two hours of the operation. If they complained of a burning sensation in the eye, the bandage was at once removed and the lower lid slightly drawn down, so as to permit of the escape of the accumulated tears; this generally affording immediate relief. The eye itself was in all cases looked at from six to seven hours after the operation, and then twice daily. On comparing the two incisions it was found that (1) the anterior chamber was reformed within

twenty-four hours in seventy-four out of the one hundred and eighty-four cases in which the corneal flap was resorted to, and in one hundred and forty-four out of the one hundred and eighty-one operated by the sclero-corneal incision; (2) primary purulent infiltration of the wound occurred twice in the first case, not at all in the second; (3) secondary infiltration following irido-cyclitis occurred four times after the modified corneal, five times after the other incision; (4) reopening of the wound was observed fifty-four times in all—thirty-eight times after the modified corneal flap incision, in six of which it was followed by purulent infiltration of the wound, and sixteen times after the sclero-corneal operation, when it was followed by no bad consequences. Atropine was always used as an aid to the diagnosis of the nature of the cataract, but was also found to be of use in the prognosis; the cases in which a maximum mydryasis was not obtained were generally found to be accompanied by a troublesome amount of bleeding after the iridectomy, rendering it difficult to remove any soft matter remaining. Before operating eserine was used, as less support, it was considered, is given to the lens when the pupil is dilated, and consequently rupture of the zonula, followed by escape of vitreous, is more likely to take place; besides, the retraction of the angles of the wound of the iris is less complete under atropine. The conclusions which the author draws from his statistics are: 1. The external wound should lie in the sclerotic; 2. The incision must be more or less curved, the height of the flap being determined by the size of the nucleus; 3. The departure from the linear wound is made up for by the conjunctival flap; 4. Artificial mydriasis is of value in the prognosis. The author also makes some remarks on the extraction of the lens in its capsule. In order to find out which kind of cases are most suitable for this operation, he carefully noted all the cases in which dislocation of the lens took place, between 1874 and 1877, during the ordinary operation properly performed. He found that in two forms of cataract an easy rupture of the ligament may be anticipated—(1) In over-ripe cataracts with a large nucleus; (2) in immature cataracts of myopic eyes, which are long in ripening and have a large nucleus. Twenty-eight cataracts, nineteen of which belonged to the first and nine to the second category, were extracted in their capsule in the following manner: After a sclero-corneal incision with conjunctival flap, followed by iridectomy, the lower portion of the lens is fixed by a large, sharp iris-hook, thrust as deeply as possible through the capsule into the nuclear substance, and causing the rupture of the ligament by pushing the lower edge backward and the upper forward. This succeeded in twenty-three of the cases, one of which was followed by irido-choroiditis and two by loss of vitreous.

—Professor A. W. Hoffmann has been appointed Rector, and Professor Schroeder Dean of the Faculty of Medicine, in the University of Berlin.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the "Transactions of the Medical and Chirurgical Faculty of Maryland," 1880, contains a paper, by Abram B. Arnold, M.D., on "The Use of the Sphygmograph in Practice."

——*Godey's Lady's Book*, for September, has a beautiful frontispiece, entitled, "Come, Baby, Come." It contains, besides the latest fashions, "The Black Hawk Waltz," by Mary E. Walsh, and, as usual, a large amount of interesting reading matter.

——"Lacerations of the Neck of the Uterus," is the subject of a paper read before the Tippecanoe County Medical Society, at Lafayette, Ind., May 6th, 1880, by A. Reeves Jackson, A.M., M.D., which now comes to us in pamphlet form, reprinted from the *American Practitioner*.

——"Optico-ciliary Neurotomy; the Proposed Substitution of a Lost and Painful Eyeball," is the subject of a paper which was read before the Maryland Medical and Chirurgical Faculty, by Julian J. Chisolm, M.D., and now comes to us in the form of a reprint from the "Transactions" for 1880.

——"The Student's Dose Book and Anatomist Combined," by C. Henri Leonard, A.M., M.D., is a neat little 16mo volume, of sixty pages, containing a wonderfully large amount of information, in condensed form, for ready reference, in the way of doses, pharmaceutical preparations, poisons and antidotes, tests, obstetrical notes, anatomical notes, etc., etc. Price, $1.00.

——"What Constitutes a Discovery in Science," and "A Reply to the Criticisms on 'The Problems of Insanity,'" are the respective titles of two pamphlets by George M. Beard, A.M., M.D., the former being a portion of the preface to the second edition of his work on Neurasthenia, the latter an address delivered before the New York Medico-Legal Society, April 16, 1880.

——The contents of *The North American Review*, for September, are as follows: "The Ruins of Central America," Part II, by Désiré Charnay; "The Perpetuity of Chinese Institutions," by S. Wells Williams: "The Trial of Mrs. Surratt," by John W. Clampitt; "The Personality of God," by Prof. W. T. Harris; "Steamboat Disasters," by R. B. Forbes; "Insincerity in the Pulpit," by Rev. E. E. Hale; "Recent Works on the Brain and Nerves," by Dr. George M. Beard.

BOOK NOTICES.

The Medical and Surgical Directory of the State of Iowa, for 1880 and 1881. By Charles H. Lothrop, M.D. Clinton Iowa. Allen Steam Printing and Binding. pp. 172.

The work before us contains the names, post office address and professional status of the physicians practicing in the State; the various medical societies, with names and residence of the officers and members; a list of members of the American Medical Association from Iowa; rosters of the U. S. Examining Surgeons for Pensions for the State; and Medical Officers of the Iowa National Guards; also Medical Colleges, State Charitable Institutions, and Hospital; State laws relating to Medicine and Surgery; fee bills of Medical Societies in various parts of the State; a mortuary record and an index of the Physicians of the State, alphabetically arranged, with reference page to register report. The book is printed on good paper, in clear type, and neatly bound in cloth.

The Practitioner's Handbook of Treatment; or the Principles of Therapeutics. By J. Milner Fothergill, M.D., Member of the Royal College of Physicians of London; Assistant Physician to the City of London Hospital, for Diseases of the Chest, Victoria Park; Assistant Physician to the West London Hospital; Associate Fellow of the College of Physicians of Philadelphia. Second American, from the Second English Edition, Enlarged. Philadelphia, Henry C. Lea's, Son & Co., 1880. Cloth, 8vo, pp. 647.

In the introductory chapter of this work the author says, that the ultimate aim of all medical research being the treatment of disease, it is desirable that a medical man be not only well informed, but also a skillful practitioner. He further states, that the tendency of recent teaching has been to rather produce the first, leaving the second quality to develop itself, or to remain in a condition of imperfect evolution, as might fall out; in other words, medicine is cultivated as a science rather than an art. The result is that the old-fashioned general practitioner is often more successful than the highly educated physician of the present generation. The object of the work before us is to place practical medicine on a more rational basis, and to enable the practitioner to understand the reasons for adopting certain therapeutical measures which experience has taught him to be effective; it is, therefore, a work on medical tactics for the bedside rather than the examination table. It is written in pleasant, easy style, and will, we feel sure, be found to be a valuable addition to every physician's library.

Fracture of the Patella; A Study of One Hundred and twenty-seven cases. By Frank H. Hamilton, A.M., M.D., L.L.D., Author of "A Practical Treatise on Fractures and Dislocations" etc. New York, Chas. L. Bermingham & Co., Medical Publishers, 1880. Cloth, 8vo, pp. 106.

Dr. Hamilton is so well known as an authority on fractures that any work from his pen will be sure to meet with a hearty reception from the medical profession in this country. In this monograph he gives the results of the study of one hundred and twenty-seven cases, ninety-nine males and twenty-eight females, which have been treated in Bellevue Hospital. Fifty-four of these cases were under the Doctor's immediate observation. The book contains a few cuts illustrating the various methods which have been devised for keeping the fractured parts in apposition, some of which are very ingenious and at the same time simple. Much information may be gained by a persual of this book.

Transactions of the American Gynæcological Society, Vol. IV, for the year 1879. Boston. Houghton, Mifflin & Co., the Riverside Press, Cambridge, 1880. pp. 506.

The number of able papers on important subjects contained in the volume before us, shows fully the life and activity of the Society. Besides the annual address on the "Gynæcology of the Future, and its Relations to Surgery," by the President, Dr. T. Gaillard Thomas, we find papers on "Hints Relative to Intra-uterine Medication," by Dr. James P. White; "Intra-uterine Medication by Iodized Phenol," by Dr. Robert Battey; "The Treatment of Puerperal Septicæmia, by Intra-uterine Injections," by Dr. Edward W. Jenks; "Cases of Sporadic Septicæmia in Gynæcological Practice," by Dr. James R. Chadwick, and several others, which want of space prevents us from mentioning. The title of these indicate their general interest to gynæcological practice. "In Memoriam to Marmaduke Burr Wright," by Dr. Theophilus Parvin, closes the volume. A general index and a copious gynæcological index are appended. We regard these "Transactions" as a valuable contribution to gynæcological literature, and the book being handsomely gotten up, in elegant cover, it will also be an ornament to any physician's library, and reflect credit on the Society.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

MEDICAL EDUCATION.

The question of raising the standard of medical education in this country, by making the requirements for matriculation more stringent, by extending the course of study to four or more years, and by enforcing a more rigid system of examination before granting diplomas, is one of great importance, as it concerns not only every physician, but every individual as well. As one of the probable results of such a change would be a diminution in the number of medical students, it would, of course, to a certain extent affect the prosperity of some of the colleges whose chief attraction is the facility with which degrees may be obtained. We could, therefore, hardly expect the co-operation of those directly interested in these institutions; but as the number of regular physicians in the United States at the present time probably exceeds sixty thousand, the country is in no immediate danger of a scarcity of doctors, even if the crop during the next few years should be short. We even go so far as to believe that both physicians and patients would gain thereby; the former by entering upon their duties in life better prepared, and with better prospects of success; the latter by the comparative security against ignorant pretenders which they would enjoy. Although many of our colleges afford opportunities for observation and study second to none in any part of the world—a fact which is amply proven by the large number of eminent physicians and surgeons which this country possesses, some of whom have never had time to go abroad—yet it cannot be denied that there exist in most of them chances for *slipping through*, which are unequaled anywhere else. Why should this be so? Why should not America, that is ahead in everything else, also take the lead in medical education? A perusal of Dr. Hardwicke's "Medical Education and Practice in all Parts of the World," will convince any one that in no civilized country but ours is it possible to obtain a license to practice medicine, unless the candidate shall have pursued his studies at some recognized medical school, for a period of not less than four years; and in some countries six and even seven years are required. In Norway, for instance, in order to matriculate as a student of medicine, the applicant has to pass two preliminary examinations: one in arts, including Norwegian, German, French, English, Latin, Greek, mathematics, geography, and history; and one in philosophy, including the higher mathematics, zoology, botany, astronomy, and the elements of chemistry and physics.

These examinations are very rigid, and eight years—ten months each year—are usually spent at college, preparing for the former, and two years at the university, for the latter. He then enters on the study of medicine proper, which occupies nearly seven years, after which, if he pass the final examination successfully, he is granted a license to practice. The examination for the degree of Doctor of Medicine is so difficult that few ever attempt to obtain it. In many parts of Europe, and in some of the South American republics, a six years' course of study is required before graduation; and while we think that this is rather severe, we can see no reason why the course should not be generally extended

to four years, and the matriculant be required to possess, at least, a common English education, with a sufficient knowledge of Latin and Greek to enable him to understand the etymology of medical terms. American diplomas would then be more respected, both at home and abroad, and the title of Doctor of Medicine would cease to be an object of sneers and humiliating remarks, such as have frequently been applied to it lately, and would be an honor to its possessor.

THE PRACTICE OF THE INCINERATION OF CORPSES.

In this country the question of the disposal of the dead is not as yet a pressing one. In all sections there is land enough to allow of large cemeteries at moderate prices. Hence the disposal of the dead in any other way than by the ordinary process of burial is really a matter of sentiment. In some minds there is a great horror of the "earthen house" which holds its tenant so long. They would much rather that the swift and bright element of fire should at once reduce their frame to ashes and air. Apparently the very limited number who have already left directions to have their bodies burned did so out of these reasons.

It is perfectly proper, and we should suppose no one would object to it, that facilities be provided to carry out such wishes. We are glad to learn that in addition to the crematory erected in this State by the late Dr. Le Moyne, we are soon to have another, and of more perfect construction, near Pittsburgh. It is the project of a retired merchant of that city. He contemplates the erection of a beautiful and attractive building, with verandahs, and without the same will be built seats for the convenience of those who may attend the cremations. The interior will be fitted up in a manner at once attractive and appropriate, so that there will be nothing repugnant to the sensibilities of any person in the construction of the whole building. The retorts will be so arranged that incineration will result in a little more than an hour. The fronts of these retorts will be of mica, so the process can be observed, if so desired. In fine, the whole building and appointments are to be marvels of convenience and scientific skill. Urns will also be furnished for the collection of the ashes. These urns will have stamped upon them the date of the birth, death, and cremation of the person whose ashes they hold, besides a place for photograph of deceased.

The arrangements will be quite as complete as in the crematories at Leipzig and Gotha. In these cities very suitable buildings and furnaces have been erected. The incineration in the latter has been said to have been accomplished in forty minutes. There is no smoke and no odor, the flames being driven in upon the body through a series of tubes, and the smoke being consumed as fast as formed. Societies have been organized in Germany for the popularizing of this method, the members agreeing that at death the society shall conduct the funeral rites and dispose of the corpse by fire.

The objection of the expense is a serious one, but by improved forms of furnaces and the greater economy of fuel they allow, this is slowly being overcome.

The only serious objection that has been advanced is that the utter destruction of the body immediately after death would destroy the opportunity to submit it to examination for medico-legal ends. This has been met by an Italian physician, who shows that such examinations are extremely rare, are nearly always of very doubtful result, and that by a simple system of checks any corpse brought to a crematory should be accompanied by unquestionable evidence of a natural death.

As we have said, the question is one of little immediate interest in this country. It is different in the crowded cities of the old world. In many of them the authorities are greatly put to it to dispose of the dead, and frequently the plan they adopt is disgusting. So in cities such as New Orleans, where it is often impossible to dig a grave of proper depth. In such instances, the erection of a well conducted crematory would be a boon which many would soon learn to esteem highly.

Notes and Comments.

Therapeutical Notes.

REMEDIES IN PRURITUS ANI WITH INDIGESTION.

Prof. J. P. Kingsley has, according to the *Southern Medical Record*, found the following prescriptions effective in a child five years of age:—

Internally.

℞.	Bismuthi subnit.,	ʒ ij	
	Syrupi simplicis,	f. ʒ j	
	Aquæ, cinnamomi,	f. ʒ j.	M.

Sig.—Teaspoonful three times daily.

Locally.

℞.	Acidi carbolici,	gtt. x	
	Empl. plumbi,	ʒ ss	
	Ungt. petrolei,	ʒ ss.	M.

Sig.—Apply.

The *Canada Medical Record*, for August, 1880, furnishes the following formulæ:—

SYMPATHETIC NERVOUS COUGH OF PREGNANCY.

℞.	Spiritus ætheris,	f. ʒ iij	
	Tinct. chloroformi comp.,	f. ʒ j	
	Acidi hydrocyanici,	♏ xv	
	Liquoris morphiæ sulph.,	f. ʒ j	
	Tinct. cardamon. comp.,	f. ʒ vj	
	Aquæ, ad	f. ʒ viij.	M.

Sig.—A sixth part every six or eight hours.

ERGOT IN PHARYNGITIS.

In chronic pharyngitis, where the blood vessels of the pharynx are enlarged and tortuous and the secretion moderate, the following is recommended:—

℞.	Ergotine,	gr. xx	
	Tinct. iodine,	f. ʒ j	
	Glycerine,	f. ʒ j.	M.

Sig.—Apply to the pharynx freely, twice daily, with a camel's hair brush.

TREATMENT OF BARBER'S ITCH.

Brame recommends the following treatment: Shave off the hairs, or cut them very short; then apply, once or twice a week, an ointment composed of:—

℞.	Prepared chalk	10 parts
	Coal tar,	1 to 4 "
	Glycerine,	5 "
	Simple cerate	50 "

ARISTOCRATIC REMEDY FOR ITCH.

℞.	Balsam of Peru,	1 ounce
	Benzoic acid,	110 grains
	Oil of cloves,	40 drops
	Alcohol,	2½ drachms
	Simple cerate,	7 ounces.

Dissolve the essential oil and the benzoic acid in the alcohol, and mix them with the cerate. Lastly, add the balsam of Peru. It is said to effect a cure in twenty-four hours.

Antiseptic Treatment of Gunshot Wound of the Knee Joint.

J. A. Holloway, M.D., of La., states, in a communication to the *Southern Medical Clinic*, that on the 5th of January he was called to see Albert Davis, colored, who had been shot during the night previous, in the lower part of the thigh, with thirty-nine small buckshot—one shot penetrating the knee joint—the patient remarking soon after the Doctor's arrival, that "all the oil had run out of the joint."

As the shot were small the Doctor thought it best not to disturb the one entering the joint, but removed those which had entered the other part of the leg, and which had passed almost through the leg, and lay just under the skin on the opposite side. As the patient objected to an amputation, the following antiseptic treatment was resorted to.

The wounds were kept dressed with carbolized oil, and over the lint were used towels wetted with carbolized water. Three drops of veratrum viride and three grains of salicylic acid were given every two hours, and his bowels were kept gently open.

On the morning of the 8th patient had very high fever, accompanied with very irritable stomach. In three days fever subsided, and stomach became quiet and nourished well. There was very little inflammation about the wounds, and one month from the date of the injuries he was up and walking about on crutches.

He lost the use of the tibialis anticus muscle for three or four months, but recovered from that with no other injury to the joint, and can now do any kind of labor.

Smallpox and Vaccination.

Dr. Mordey Douglas, of Sunderland, writes to the *British Med. Journal*, that the smallpox epidemic of 1870, which was more fatal in Sunderland than in any other town in the kingdom, afforded him an opportunity of judging for himself of the protective and modifying influence of vaccination. Of the 211 cases which came under his own care, and of which careful records were kept, 180 were among the vaccinated, and 31 among the unvaccinated. Of the vaccinated, only 4, a little more than 2 per cent., died; while 15, or nearly 50 per cent., of the unvaccinated succumbed. The four vaccinated who died had all been very badly vaccinated. He was particularly struck with the way in which the disease showed itself in one family. A fine, strong, healthy young man, aged 23, unvaccinated,

developed the most loathsome, dreadful case of smallpox, he had ever seen. Both he and his equally strong sister, aged 21, also unvaccinated, died; while their two little brothers (9 and 11), who presented evidence of having been fairly well vaccinated, took the disease in a very mild form. There were also other cases which impressed him strongly. For instance, he had three cases in which, while the vaccinated mother presented perhaps a dozen or twenty pocks, her unvaccinated infant was literally covered with eruption, and, of course, died. He further says, that although ten years have elapsed since the epidemic, he does not remember to have seen, among the thousands of children which have passed through his hands, at the Sunderland Hospital for Sick Children, a single vaccinated child pitted with smallpox during the whole of the time.

Apparent Death as a Result of Asphyxia.

Medical journals, says the *Medical Press and Circular*, occasionally inform us of wonderful resuscitations brought about by the persistent use of artificial respiration; but two, lately reported to the Academy of Sciences, Paris, by Dr. Fort, Professor of Anatomy in the École Pratique, are especially noteworthy, and teach us to persevere in any efforts we may make to bring back signs of life. In the case of a child three years old, who had already been placed in his shroud, Dr. Fort commenced the use of artificial respiration three and a half hours after apparent death. After four and a half hours of steady work the child was brought back to life. The other case was that of a drowned man, who had been under water for twelve minutes before the body was recovered. Artificial respiration was commenced an hour afterward, and after being kept up for hours the man was restored to life. The report of the meeting of the Academy does not give the details of the child's case before the appearance of the apparent death, nor what prompted the doctor to commence the artificial respiration.

Carbolized Camphor in Diphtheria.

The *Medical Press and Circular* informs us that Dr. Peraté has for the last two years employed carbolized camphor in the treatment of diphtheria. He applies it by means of a brush soaked in the following solution: Phenol (carbolic acid) nine grams; camphor, twenty-five grams; alcohol, one gram; diluted with an equal quantity of almond oil. The applications are made at first every two hours during the day, and every three hours during the night, and the interval between them is gradually increased. The application is made over the whole of the false membrane, and in refractory children the brush is plunged well to the back of the throat. The taste of the mixture is very disagreeable, but patients soon become accustomed to it.

Certain Points Connected with Albuminuria.

Dr. Saundby, in an able paper in the *British Medical Journal*, June 5, 1880, reviews the whole subject of albuminuria, that is, "the presence in the urine of a body coagulated by heat, or precipitated by neutralization." There being but two albuminous substances likely to be met with giving the above reactions, viz., serum-albumen and paraglobulin, Dr. Saundby endeavors to decide whether paraglobulin is ever found alone in the urine, although it is constantly present with serum-albumen. A series of carefully arranged experiments and observations appear to warrant the following conclusions. 1. The body present in urine which is coagulated by heat, or precipitated by neutralization, is almost invariably serum-albumen, rarely paraglobulin. 2. The presence of paraglobulin alone in the urine is still somewhat obscure, and has not been correlated with any clinical group of cases. 3. The maximum amount of albumen excreted by the kidneys is during the after-breakfast period, and this relation is maintained in spite of the more albuminous character of the mid-day meal. 4. While there can be no doubt that nitrogenous diet increases albuminuria, this is not due to the absorption of undigested albumen, but to the increase of nitrogenous excreta, and the consequent stimulus to the usual functions.

Bromide of Potassium Spray in Whooping Cough.

The good effects of bromide of potassium in the treatment of whooping cough are well known to all practitioners. According to Dr. Wintreben, in *La France Médicale*, the action of this remedy may be made still more efficacious by bringing it in contact with the mucous membrane of the air passages in the form of spray. The author habitually uses a solution of bromide of potassium, one in twenty, and repeats the application of the spray for one minute after each fit of coughing, when the mucous membrane of the breath passages, free from the mucus which usually covers it, is accessible to the action of the remedy.

Correspondence.

The Non-Conductivity of Fat.

Ed. Med. and Surg. Reporter.

In an interesting case, relative to the non-conductivity of fat, reported in the Cincinnati *Lancet and Clinic*, by Dr. E. S. Boland, of Boston, an abstract of which appeared in a recent number of the Reporter, he thinks he has verified his proposition by making an autopsy on a stout, very obese woman, who died at the end of a week of acute mania, and in whom he found the portal temperature 110.5°F. She had then been dead two hours and fifteen minutes, had been washed and laid out, and had an ice-tank on her chest and abdomen for fifteen minutes prior to commencing the autopsy. He also says: "The interesting feature connected with this case is, the persistence of the interior heat, after bathing, ice applications, etc."

While admitting that fat is, in a measure, a non-conductor of heat, should we, in this case, attribute the high temperature of the portal system to this fact alone? May not the *very means used to cool* the body have concentrated the internal heat in the liver, thereby raising its caloric to 110.5°F., which was probably a higher degree than ever reached during her life? This idea was suggested to me by an old experiment Prof. Bache, of Jefferson College, used to make before his class, a quarter of a century ago, viz: after heating half a gallon of water in a retort, to ebullition, he would extinguish the fire, and throw cold water upon the surface of the retort, for a dozen or more times, at intervals of a minute or more, when the water would boil freely in every instance.

Of course, this phenomenon was the result of both condensation of steam and concentration of heat.

James E. Daniells, M.D.

Baltimore, Md.

How to Make a Cheap Galvanic Battery—Additional Suggestions.

Ed. Med. and Surg. Reporter.

Since the publication of my article in the Reporter, of July 3d, several inquiries have been received by mail on certain points not understood by those who are probably novices in electro-therapeutics. These refer principally to the solutions, and as time and engagements will not permit separate answers, a few remarks in the Reporter may suffice, inasmuch as all will thus see them. That the directions in the article on construction are clear enough is evidenced by the fact that within my own knowledge three batteries have been already made by gentlemen who were not familiar with the subject before its publication.

First Point.—The simplest solutions to manage are, cupric and zinc sulphate. Keep a reserve supply of each in a large champagne bottle. Where the battery is used an hour or two daily water alone will be needed for three months, unless a cell gives out. If the copper solution *bleaches or turns yellow* throw it away and renew from the reserve. If the zinc solution becomes discolored *in any way* renew it. Examine the cells once a week throughout, and the plates need not be disconnected to do this; lift them out carefuly, but see that connections are *tight* when they are replaced in the cells.

Second Point.—The copper plates are not sensibly worn for a long time—mine are good yet, and, in the particular battery described, are over two years old. The zincs wear in proportion to the use of the battery, and are little acted on when at rest, provided always that the circuit is broken after ceasing its use. As the anode and cathode are in different cells, there can be no internal action beyond that caused by deposition of copper upon the porous wads, which, however, always takes place first on the under side, and should be detected long before penetrating through to the inside of the tube. Sheet zinc turns black at once, which does not matter; but if it gets scaly, scrape or wash it thoroughly. If flakes from it deposit in the tube, remove them by filtering, or renew the liquid. When, with good connections, the power fails to a decided degree, renew the solutions throughout

Third Point.—Few electrodes or rheophores are needed, but these depend on the taste or skill of the operator. The better plan at first is to select a few of them from an illustrated catalogue, which can be obtained from numerous dealers; thereafter make your own.

Wm. R. D. Blackwood, M.D.

246 *North Twentieth street.*

News and Miscellany.

Union Medical Association.

The third annual meeting of the Union Medical Association, composed of the Lancaster, Chester, Berks, Dauphin, Cumberland, Schuylkill, Harford and Cecil County Societies, took place at Tell's Hain, about one mile from Lancaster, Pa., August 26th. Representatives from all the counties named were present, and many of the physicians were accompanied by their families, the assemblage numbering between two hundred and three hundred people. A business meeting was held at 10.30 A.M., after which Dr. John L. Atlee, President of the Association, delivered an address. Dr. Atlee, though an octogenarian, is as hale and hearty as most men of fifty, and can enter into the spirit of an occasion like this with a zest equal to any of them. At 1 o'clock a magnificent banquet was spread, and toasts and responses of an exceedingly interesting character were indulged in. It began raining about noon, but Tell's Hain is fortunately provided with a commodious building, and here the pleasure seekers found ample accommodation, and the rain did not in the least dampen their ardor. The Committee of Arrangements, to whom the success of the affair was largely due, was as follows: Dr. George R. Welchaus, Chairman, Lancaster; Dr. Paul A. Hartman, Harrisburg; Dr. W. Stump Forwood, Darlington, M.D.; Dr. Alexander Craig, Columbia; Dr. John Montgomery, Chambersburg; Dr. D. D. Kennedy, Oxford, and Dr. R. H. Miller, Delaware County.

Three Unqualified Practitioners Sentenced to Death.

The *Medical Times and Gazette*, August 14th, 1880, says:—

Society may be congratulated upon the fact that within the past week three persons belonging to the class which preys upon the weakness of human nature have been brought to justice, and found guilty. At the Warwick Assizes, a man named Haywood was indicted for the willful murder of a young woman residing at Birmingham, whose post-mortem examination showed that the deceased died from blood-poisoning arising from an internal wound, the position of which left no doubt that it had been inflicted in an attempt to procure abortion. And at the Central Criminal Court, a man and his wife, who dexterously carried on their traffic as herbalists, the one at Bristol the other at Yeovil, were found guilty of the murder of an unfortunate woman who had been induced to submit to an operation to procure a miscarriage. Sentence of death was passed in each case, and all the prisoners were recommended to mercy. The sentence of the law will not, therefore, be carried into effect; but at any rate, as all the prisoners are persons advanced in years, there is no fear that they will again be let loose to prey upon the weak and foolish.

A Tax on Privies and Sewers.

The *Bombay Gazette* reports that Mr. Crawford, the second Assistant Collector, and Vice President of the Municipality of Dholka, Ahmedabad, has issued a notice imposing taxes on houses, *privies and sewers*. Eight of the unofficial members of the municipality, having in vain protested against this taxation, on the ground that the people were too poor to bear the burden, have tendered their resignations, and memorialized the Governor of Bombay on the subject. The taxation of privies and sewers is a novelty to us, and indicates curious views of political economy on the part of the promoters. "We could understand," says the *Lancet*, in commenting upon this, "a public grant of money for the purpose of encouraging persons to construct privies and sewers, but privies and sewers as a source of revenue is a form of taxation which must be classed with that barbarous form of which we had an example here in the window tax."

Infanticide.

The law in Schwetz, Switzerland, as just adopted by the local legislature, very singularly makes a distinction between legitimate and illegitimate children. The crime of infanticide will be punished with death only when the victim is a child born in wedlock.

OBITUARY NOTICES.

—Professor Ferdinand Von Hebra, the distinguished dermatologist, died in Vienna, on August 25th, at the age of 64.

—Dr. Eugene Broadmeadow, of Clifton, N. J., seventy-one years of age, and one of the oldest practicing physicians in that State, died at Ocean Park, suddenly, of heart disease.

—We are also informed that Dr. T. J. Thomason, of Perrineville, N. J., died on the 21st ult. Dr. T. was formerly President of the New Jersey State Medical Society, and had filled other prominent positions in the State.

—We are sorry to learn of the death of Dr. Frank H. Davis, of Chicago, which occurred on the 22d ult. Deceased was the son of Professor N. S. Davis. He was a young physician of no small ability, and devoted much of his time to medical literature.

—Dr. Henry M. Bedford, of No. 66 Fifth Avenue, New York, died, August 19th, at Richfield Springs, of a lingering illness. He was a son of the late Dr. Gunning S. Bedford, in his time one of the most distinguished physicians of New York, and a brother of ex-City Judge Gunning S. Bedford, and of Dr. Frederick Bedford. He was unmarried, and about thirty-eight years of age. He formerly had a large practice, which he was compelled to relinquish in consequence of failing health.

QUERIES AND REPLIES.

A correspondent asks some one to give him a good remedy for corns.

Dr. E. M. M., of New York State, requests some one to give him a remedy for the itching of the scalp and falling off of the hair.

MARRIAGES.

BRYANT—FISH.—In Austin, Minn., July 22d, by Rev. C. D. Belden, Dr. J. H. Bryant and Mrs. C. A. Fish, both of St. Paul, Minn.

CLARK—ALTHAUSE.—In New York city, August 16th, 1880, at the residence of the bride's parents, by the Rev. Rufus W. Clark, D.D., William W. Clark, M.D., of this city, and Mary Louise, youngest daughter of John J. Althause, Esq.

GARDNER—GARDNER.—August 11th, 1880, at the residence of the bride's father, by the Rev. G. C. Lyman, Dr. H. D. Gardner, of Beaumont, Pa., and Miss Addie Gardner, of Dalton, Pa.

LA ROCHE—MONTGOMERY.—In New York, August 4th, by Rev. John S. Gilmor, Dr. Phil. B. La Roche and Lurana Warner Montgomery, all of New York city.

RYALL—HEARST.—July 21st, 1880, at the residence of the bride's parents, by Rev. J. P. Black, assisted by Rev. John Foy, Thos. Ryall, M.D., of Savannah, O., and Miss Kate E. Hearst, of Salem, Nebraska.

STOUGH—PRESTON.—August 10th, 1880, at the residence of the bride's mother, by Rev. J. W. Reese, Dr. J. F. Stough, of Niles, O., and Miss Rachel Preston of Lordstown, O.

TEBBETTS—BIBBY.—In Hanover, N. H., June 29th, by Rev. S. P. Leeds, J. W. Tebbetts, M.D., of Manchester, and Annie Bibby, of Hanover.

DEATHS.

BEDFORD.—At Richfield Springs, on Friday, Aug. 20th, Henry Moore, eldest son of Jane M., and the late Dr. Gunning S. Bedford.

PERRY.—Suddenly, at Garrison's, Aug. 17th, 1880, Helen Doty, wife of Dr. Stafford G. Perry, of New York city.

SIMPSON.—At Hudson, N. Y., on the 25th ult., Dr. E. Simpson.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1228] PHILADELPHIA, SEPTEMBER 11, 1880. [Vol. XLIII.—No. 11.

Original Department.

Communications.

SOME POINTS IN THE ETIOLOGY OF TYPHOID FEVER.

BY SAMUEL PETERS, M.D.,
Of Cohoes, N. Y.

The object of this paper is to briefly review some of the opinions entertained by the medical profession on the subject named, and, if possible, to contribute a single mite toward the settlement of some of its vexing questions. Scarcely a journal comes upon our table that does not contain some discussion on one or more of the topics involved; and the difficulty of classifying all the arguments and weighing the conflicting testimony becomes, to the busy practitioner, so great that he is tempted to abandon it altogether.

Probably no disease is so unsettled in regard to its causation as typhoid fever. I propose to classify, if possible, these existing opinions, and attempt the task of bringing to view the doctrines of each, weighing and comparing all with a spirit of strict impartiality. Individuals are nothing, facts everything. Nevertheless, medical men will differ, as they have since the world began. One forms a theory, another directly opposes it; a third sweeps both away in a single sentence; and in the meantime typhoid fever moves on in its work of carrying away more than a hundred thousand of the human family every year, thus urging upon us the necessity of making haste to uncover the hidden truths and arrest such a frightful sacrifice of human life. In the present state of our knowledge, can this be done? Viewing its etiology in one light, we may answer, yes; in another, no, only as we can improve in our knowledge of its nature and treatment.

If we believe, with Budd, Parkes and others, that it has the same contagious nature as smallpox; that with certain precautionary measures and the free use of disinfectants the disease may be wiped out entirely from the face of the earth; certainly it is our duty to understand and follow well these directions. If, on the other hand, we believe, with Greisinger, that typhoid, aside from its contagiousness, may and does often originate spontaneously, certainly we cannot hope for such a desirable end. Again, if we believe, with Edwin Snow, Registrar of Providence, that this disease "arises solely either from cesspools, privy vaults, sewers, or chiefly from the decomposition of vegetable substances," then our only hope rests simply upon our skill in treatment.

By examining carefully the medical literature upon the question of etiology, we find four classes of opinions:—

1. Non-contagionists.
2. Direct contagionists.
3. Miasma contagionists, of Liebermeister.
4. Contagio-pythogenicists.

The Non-contagionists, represented by Ewen, Wood, Lindwurm, and Huss, class typhoid with such diseases as pneumonia, miasmatic fevers, etc.

The direct contagionists, represented by Budd, Roberts, and others, class typhoid fever with smallpox, typhus, scarlet fever, etc. This class is not large at present, and is undoubtedly finding less and less advocates, being properly a relic of the time when the distinction between typhus and typhoid was not generally made; the former

ot which is everywhere acknowledged to be contagious.

The miasma contagionists, properly represented by Thiersch, of Erlangen, and Liebermeister, are entirely opposed to the doctrine of direct contagion from person to person, as in smallpox, but believe in a specific poison of such a nature that it is only perfected and rendered operative some time after leaving the body of the typhoid patient.

The contagio-pythogenicists, represented, as I deem it, by Trousseau and Niemeyer, maintain that typhoid, while it is communicable by contagion, may, under favorable circumstances, originate spontaneously.

The great importance of the subject will lead us to examine it somewhat carefully; divesting ourselves of prejudice, as Liebermeister so frequently urges in bringing forward his carefully collected and powerful arguments, so that facts and not theories alone shall aid in building up a belief which shall direct us in a practice tending to eradicate from the human family what is eradicable.

Contrary to the opinion of the first class, the non-contagionists, we remark, that typhoid fever, as well as cholera, dysentery, and yellow fever, must possess some sort of contagion, either direct or indirect; some specific power of propagating itself by generating its own specific poison. This we think is, at the present day, almost universally admitted; a general belief, pervading the laity as well as the profession in all countries, founded upon the accumulated experience and observations of the last quarter of a century; and hence, it finds its expression in the rules of all quarantine and health boards, so far as we know. Therefore, we need not spend much time in discussing the subject, any more than to name the following points in proof.

1. Typhoid fever, as in other contagious diseases, very seldom recurs in the same individual. In thirty-five years' experience I have never but once seen a person attacked a second time. (Budd, Liebermeister, Wood, Flint, Alonzo Clark, Aitken.)

2. As in other contagious diseases, this is attended with a constant eruption on the mucous membrane; generally, also, on the skin.

3. Typhoid may very frequently be traced to a preceding case, as in other contagia, and could undoubtedly be commonly so traced but for the special nature of the contagious principle, it being only *partially* developed on leaving the infected body; and

4. A focus of infection, either from the excreta of the diseased body or of spontaneous origin, once made known and removed, the further spread of the disease is arrested. Such facts are not rare, and will be again referred to in this paper.

Next, in opposition to the doctrine of the direct contagionists, it seems evident, at least to my own mind, that the very broad ground taken exposes them to attacks from so many quarters that their system is rendered quite untenable. In classing typhoid fever with smallpox and syphilis, the very types of all contagious diseases, they must show that in the large majority of exposures the disease must be contracted. This must be the rule; the exceptions very few indeed. Now, in order to prove this they must show, first, that a case occurring in a family must produce the same in all the other members who have never passed through it; and secondly, that for every existing case they must find one that preceded it, and between these two an actual contact. Such strong doctrine is, however, modified by some, who believe, like Flint, that typhoid is only *mildly* contagious, many contracting it after fair exposure and many escaping. This line of theory is harder to deal with, for it is easy to admit of many exceptions. Even these however, must show that it is exceedingly common to see attendants, visitors and physicians falling under the disease. I am *not* aware that they have been able to do this. Contrary facts however, are abundant, and will be presently referred to. I have, myself, witnessed, in private practice, something over six hundred cases, from almost as many different families, and having never seen, except in comparatively a very few instances, the occurrence of more than one case in a family, and these exceptions mostly traceable to a focus of infection, I cannot but form the belief, indeed the firm conviction, aside from the mass of testimony from others, that there is no such thing as direct contagion.

Visitors and physicians enjoy almost a perfect immunity from the disease; even those who wash the soiled clothes for typhoid persons are remarkably exempt, unless they have remained unwashed for too long a time. I have always permitted friends to call, with the assurance that the danger was simply *nothing*. Liebermeister never saw "a single hospital patient, physician or nurse attacked with typhoid fever, although such cases were placed in the general wards." Murchison's experience was the same, with the exception of eight cases only, among two thousand five hundred and six. This small

number will certainly allow us to assume that these originated probably from some local cause or condition, and argues strongly against direct contagion. Andral and Chomel are equally emphatic in asserting like experiences. Therefore, it seems far more scientific to look for some other explanation than one that has such a preponderance of exceptions. True science, we think, never admits of such loose reasoning as this.

The doctrine of the third class, namely, that of an intermediate development of the specific contagion, that is, the necessity, in order for its final perfection, of a period of existence outside the body, is really ingenious, and has many points that are strong, if not incontrovertible. It is a doctrine fully discussed in Ziemssen's Cyclopedia, by that most careful observer, Liebermeister, and although not new, is no doubt eliciting the careful attention of the medical world. It very readily explains why typhoid, cholera, etc., are infectious, though not directly contagious; why the contagious particles are capable of maintaining a separate existence after leaving the body for an indefinite time, and even of mingling with streams, reservoirs or underground currents of water, and infecting persons at a distance and entirely separate from any typhoid patient; how an epidemic or endemic may be originated in some isolated place by means of fomites, or by the purchase and use of contaminated milk, or by the fecal deposit of some typhoid patient some time previous, or by the use of water from some infected well or fountain. Plenty of proof from actual occurrences can be cited upon all these points. In most of the later writings on the etiology of diseases of the class named may be found descriptions of such instances. Similar instances are no doubt familiar to all who have sought for them during an epidemic particularly.

If what has been said under the head of direct contagion be true, namely, that it is an impossibility, it is very evident that the virus must be imperfect and inoperative at the time of its leaving the body. It is equally evident that it must afterward attain its perfection, otherwise there would be no contagion at all. The adherents of this theory of an intermediate state of the specific virus bring as proof not only what has already been said in relation to this point, but that comparison is readily drawn from the animal kingdom; facts that are well known. The tape-worm, insects, etc., for instance, have different stages of existence; the tape-worm, after leaving the ovum, penetrates the fleshy tissues and becomes encysted; so remaining until the flesh containing these cysts is eaten by some other animal, when the perfect worm is developed. Insects have the larva, or worm stage; the pupa, or transforming stage; then the perfect insect. So with the germ, if it be a germ, which we doubt, of typhoid virus, as will be seen further on. It comes from the body in the first or imperfect stage, finds a favorable soil in privy-vaults, sewers, or other places where there is decaying animal or vegetable matter, and there grows into its perfect or active state. It may then find its way into streams or reservoirs of water, or be carried by the air ready to infect the human body. Numbers of instances might be cited showing clearly the formation of such centres of infection. I have myself known instances of this kind. One I will mention, that occurred in the country. A case of typhoid appeared in a family of eight persons. In about two weeks another occurred in the same family; a careful examination of the surroundings impressed the idea that the cause existed in a well of water used by the family. Soon another came down with the disease, and still others were complaining of slight indisposition. I ordered them to discontinue the use of the water from this well, and no more cases occurred. The well was suspected on account of its near proximity to a privy vault. Dr. Stoddard, in the "Transactions" of the New York State Medical Society, records a similar instance in Rochester. Others are familiar, where milk diluted with infected water, or the milk-cans washed with such water, have caused cases from which many others were infected. Instances are too numerous where schools, families and towns have been infected from like causes.

But while this very plausible theory is capable of explaining nearly all the points involved in the discussion; while its ingenuity and application are beautifully adapted to arouse the attention of physicians to the preventability of typhoid, and will, therefore, surely result in good, by greatly lessening the number of cases, yet, it seems probable, at least to my own mind, that it cannot meet *all* the requirements of a settled and universally adopted theory. Every philanthropist could well wish it true, because, involving as it does, a continuous chain of actual cases, it is plain that if this chain be broken fairly; if in the few last cases every specific germ or particle be destroyed, the fond hopes of its advocates would soon be realized, and typhoid fever would be among the things of the past. We fear, however, that the thought is too flattering to be admitted among the grand possibilities; that it

makes the herculean task too easy. And while we might pray for its speedy realization, causes for doubt will force themselves upon us almost every day.

Hence we come to notice, and to adopt, if you please, the theory of the fourth class above mentioned, viz.: the contagio-pythogenicists, who adopt the doctrine of miasma contagion, as just described, *with* the doctrine appended to it that, under favorable though perhaps rare circumstances, the typhoid virus may be formed and perfected away from and entirely independent of any person having the disease; in other words, that it may originate spontaneously, and when thus originated, it is capable of generating itself in the body of an affected person, just in the same way as others who contracted the disease from actual contagion.

Without admitting the possibility of spontaneous origin, how can we explain fairly and without any labored hypotheses, those isolated cases that so commonly occur in the open country, here and there one, widely separated, far away from every exposure, among the steady farmers, who are always at home; or among lumbermen, perhaps, far away in the forest, dwelling often miles apart? Such facts are exceedingly common, and they are repeated year after year, leading the mind, I was about to say, inevitably to the conclusion that they originate *de novo*. Why must we strain every power of conception to believe that a preceding case brought such an one into existence? Surrounded by such striking and often-repeated facts, it would seem *natural* to deduce the doctrine of spontaneity.

I use the term "natural," and will illustrate by supposing a case. Let ten physicians, without special instructions in the etiology of typhoid, commence practice, specially in the country, "which is the proper place," as Dr. Dorset. of England, remarks, "to form correct conclusions in the matter," and nine of the ten will form the opinion that it arises spontaneously. In densely populated cities it is no wonder that opposers of the doctrine of spontaneity are numerous, and find little difficulty in believing that all the cases that occur are really connected one with another, because contact, directly or indirectly, is so easy, and that it is not necessary to even dream of the possibility of spontaneity. But in the country, open and sparsely settled, it is far otherwise, any contact between them seeming to be almost an impossibility; and while the plain fact may be and is urged with all the force of words, little heed is given to it by those whose professional lives are spent among the crowded thousands; such continue their skepticism because they view the subject from one side only, and are unable to look at it from the other.

Much additional testimony on this point might be brought forward from others; those, even, who differ widely on other points. Murchison, of the London Fever Hospital, whose opportunities for studying this fever were equal, at least, to those of any other man, has staked his reputation by giving it the name of "pythogenic fever," meaning, of course, a fever *arising from putrefaction*. Snow, of Providence, City Registrar, who is a careful observer, and has good opportunity for studying this disease, publishes the same opinion, in very decided language. Dr. Barker, of Bedford, England, believes also in spontaneous origin. Dr. Piedvacke, another most careful observer, found at least twelve cases out of three hundred and twelve, that by the most careful search could *not* be traced to any anterior connection, direct or indirect, with any other patients." Even one such case, really genuine, would, of course, settle the question. Sir Wm. Gull calls it "the filth fever." Flint maintains that "it frequently or generally originates spontaneously." George B. Wood speaks even more decidedly. Tanner says it is generated by putrefying animal matter; and it is well known that Trousseau, Bennett and Niemeyer maintain the same opinion.

An argument made use of by the opponents of spontaneity is, that the spontaneous generation of typhoid can no more occur than the spontaneous generation of plants and animals, the possibility of which is now abandoned as a myth; that though the disease was first originated or created, so to speak, it cannot be *recreated*, any more than the Almighty will recreate an animal or plant that already exists. The force of this argument we must admit, were it not that it has the fault of being predicated upon an assumption, that the specific virus is living or organized matter. This, as all know, is a revival of the ancient doctrine of a "contagium vivum;" certainly we have no objection to this if the doctrine be the true one. But we have no more right, and certainly no more reason, to assume that the contagious matter is organized, than we have to assume that it is a chemical or matter that is unorganized.

What the chemical is, if it be one, may never be determined, for certainly it has not been as yet; some have supposed that certain gases might be acting agents; and various ones have been tried on dogs, birds and other animals, by

Drs. Barker, Murchison and others, but all such experiments failed to produce symptoms like typhoid fever. The probability is, that it is by no means a common product; but on the contrary very rare, seldom, and only under the most favorable circumstances, formed.

Now it cannot be disputed that a specific inorganic body can produce a specific effect upon the human organism as well as a germ. That it can, we see every day, in our practice. Both organic and inorganic remedies affect particular organs, no matter how applied or introduced in the body. Thus, we have cathartics, diaphoretics, diuretics, etc. Probably every article has its special action upon a special organ; hence we are able to modify the action of the heart, the kidneys, the skin or the bladder. Why may not a certain chemical agent act through the body upon the glands of Peyer, producing typhoid; the poison discharging itself there in a condition ready to go through some specific change and become a real contagium? The same reasoning that applies in one case applies also in the other, and the theory of the spontaneous origin of the contagious virus, which has been held from time immemorial, be sustained.

A query may arise in reflecting upon the details of this supposed chemical; how can it (the virus) enter the body perfect, pass out imperfect, destitute of the contagious principle, and then become perfect again outside the body? The answer is, that very many substances are changed in their course through the body, as is well known; some in the stomach, some in the intestines, some in the blood, and some in the organs or tissues by which they leave the body. Benzoic acid, for instance, is eliminated by the kidneys as hippuric acid. Indeed, many are the changes that must occur. In order to make more clear the idea, we will imagine a case such as may, and probably does happen; similar ones certainly do. Suppose an oxide or a sulphide is taken in the stomach, and in its course through the system the oxygen or the sulphur is separated, the base appearing again in the fæces, having passed through Peyer's glands, or reached the alimentary canal in some other way; or appearing in the urine through the kidneys. This base having an affinity for the oxygen or the sulphur, recombines with it, outside the body. It would again become what it was on entering the stomach. This, of course, is merely a supposition, and without any pretence as to what the contagious substance really is. At any rate, such a conception has an abundance of parallels.

The second objectionable point against the contagium vivum theory which we will mention is this: It requires always the planting of the actual seeds or germs to produce the real contagion; whereas the chemical theory waits for no such thing, as none is required; chemical changes are continually going on; combinations formed and decomposed; changes that probably have never been imitated by the chemist, and perhaps altogether unknown to him.

Such are some of the reasons for adhering to the doctrine of the spontaneous generation of typhoid fever. Others might be brought forward, as for instance: In order to explain the contagium vivum theory, its adherents must assume that the contagious germ is capable of maintaining an existence under a variety of conditions; not only on the surface of vaults, sewers, or cesspools, but percolating through the dense soil, and far underground; or mixed with various fluids, as milk, water, fecal infusions, etc. Now we know that many of these low organisms cannot maintain vitality under such widely different circumstances. But suppose they allege that the contagium dies, and its substance becomes infused in such mediæ, and is thus transported. We know that organic matter, even in such infusions, readily decomposes when submitted to such varying influences. In either case the assumption is unnaturally or unduly strained to accommodate all the requirements of such an hypothesis.

We repeat, then, the query, Is the contagium of typhoid fever organized matter? We answer, it has not been proved. Neither is there an argument to support it that will not apply to the theory that it is unorganized. But let us invert the proposition. Has the theory that it is unorganized any argument that will not apply that it is a germ? We answer, yes, namely: that thousands of cases occur that, with our best reasoning and closest scrutiny, we have a right to assume originated *de novo*.

We think, therefore, in conclusion, that we have the best and the largest share of evidence, that two of the doctrines that have prevailed in reference to the etiology of typhoid fever, namely, non-contagion and direct contagion, must be abandoned; that indirect or miasma-contagion is correct as far as it goes, but that it does not comprehend or contain the whole truth until we add to it the possibility that cases may originate spontaneously. With a theory so constructed, I think we are able to explain, with reasonable satisfaction most, and may we not say all, the intricacies that may arise.

TRANSFUSION—THE INDICATIONS FOR ITS USE AND THE METHOD OF PROCEDURE.

BY A. O. STROUT, M.D.
Of Parkersburg, Iowa.

This operation has been vaguely known to the profession for the last four hundred years, and there are obscure allusions in the Roman poets which would seem to indicate that it was practiced as early as the "Augustan Age."

"Ut repleam vacuas juvenile sanguine venas."
(OVID).

The earliest authentic case on record is, so far as we know, that of Pope Innocent VIII, who was unsuccessfully operated on in April, 1492. The vital powers of Innocent VIII rapidly gave way; he had for some time fallen into a kind of somnolency, which was so profound that the whole court believed him dead. All means to awaken the exhausted vitality had been resorted to in vain, when a Jew doctor proposed to do so by the transfusion, with a new instrument, of the blood of a young subject. An experiment which had hitherto only been made on animals. Accordingly, the blood of the decrepid old pontiff was passed into the veins of the youth, whose blood was also transferred into those of the old man. How it was done the report does not state; but the experiment was tried three times, and at the cost of the lives of three boys, probably, from air getting into the veins, and all without any effect to save that of the Pope.

A Tuscan, by the name of Francesco Folli, in the year 1852, first made a decisive advance, by which theory and vague ideas were abandoned, and gave place to the experiments which Folli in that year practiced in the Court of Florence, in the presence of the Grand Duke Ferdinand, II. In the "Stadera Medica," a valuable work published in 1660, by Folli, he recalls the fact that he suggested transfusion in certain of his works of a date anterior to 1657. That is when the English Wren instituted his experiments, to whom Sprengel, ignorant of this fact, attributes the first experiment. Harvey, about the year 1657, suggested it, and some years later it was done. Shortly after (Lauer), of France, practiced by injecting into one animal the blood taken from another. Folli and Wren limited themselves to experiments on animals and did not attempt to test them on man. The last step was to perform transfusion between animals and man, and finally between man and man. From the success of Douay's (a French surgeon) experiments, great enthusiasm was created, but from the many deaths hat occurred, it was, on the 17th of April, 1668, prohibited, unless by express permission of the Faculty of Medicine of Paris.

The transfusion of blood, from the date of its promulgation in France, Italy, Germany, and England, rapidly roused furious adversaries, who made it a subject of acrimonious disputation similar to what we have seen about animal vaccination. On the other hand, its fanatical supporters, going to the other extreme, beheld in it a panacea which would maintain youth, reestablish health, alleviate mental ailments, change the hereditary disposition in certain affections, and prolong life beyond its natural limits. In 1685 Harwood bled an old horse to the last extreme, then injected into his veins blood from another horse. After the transfusion the horse that had been ex-sanguinated arose and began to feed. As it was in France, so was it in Italy; the transfusion of blood was abandoned by every one, with few exceptions, till the beginning of the present century. For when a man was racked for affirming that the earth moved around the sun, we can readily understand that the members of the healing brotherhood, in the Middle Ages, had to proceed in all their investigations with fear and trembling. In 1802 Michele Rosa renewed the neglected animal experiments, and it is at this time that we see the beginning of the substitution of transfusion from man to man, for that from animal to man. In 1819 Blundell, of London, performed numerous experiments. His cases numbered six; for a time they improved, but eventually they died. These operators all used the method of direct transfusion.

In 1859 Waller injected nine ounces into a patient, which resulted in complete recovery. This was by means of the indirect method.

Martin, of Berlin, has published fifty-seven cases, forty-five of which recovered. The cause of the exsanguination was post-partum hemorrhage.

In 1864 Graily Hewitt and B. W. Richardson turned their attention to this subject, and in 1868 Braxton Hicks reported six cases; but unfortunately all of his died.

Brown-Séquard has bestowed a great deal of time and energy in experimenting upon this subject, as also the late Dr. Freer, of Rush Medical College, with whom I think it was almost a hobby. But I have not been able thus far to discover any record of his cases, although I think he published a small work embodying his ideas of the subject. Numerous others are working up this subject at the present time, but it is not necessary to give their names.

In spite of its non-appreciation by physicians

in general, there have always been eminent men in the profession who placed in transfusion of blood confident hopes of certain future advantages for suffering humanity. For if facts overcome all arguments, facts authentically established are not wanting, to prove that transfusion performed properly is able, in many cases, to arrest the otherwise inevitable issue.

The most important indication for transfusion of blood is naturally acute anæmia, and the most frequent example of this we find in midwifery. We should be guided here chiefly by the contractions of the uterus. Provided they are energetic, we may delay the operation, but should the uterus be unable to contract, transfusion is the most powerful stimulus for the purpose we have at our command. In great loss of blood after injuries or operations, however, the surgeon should never wait. It appears that the German surgeons employ transfusion much more freely than is generally supposed. For instance, Esmarch, during the removal of a vascular tumor at the base of the cranium, replaced the lost blood by transfusion in the arm, and during an amputation at the hip joint the blood was saved and injected into the body again through the femoral vein.

Leisrink recommends transfusion in convalescence from typhoid fever, or from any long febrile disease which leaves the body so exhausted that any slight intercurrent disease might prove fatal.

Among the qualitative changes of the blood we find transfusion of importance in pyæmia and septicæmia. The transfusion should be frequently repeated. Of course this treatment is useless, provided the source of the blood poisoning remains.

It might also be used in the various forms of gas poisoning, and in such cases as much as possible of the unhealthy blood should be removed at the same time.

Case 1.—Professor Heuter of Griefswald, related a case of poisoning by CO_2. Patient, aged 26, had been exposed to the gas and found insensible. Attempts to resuscitate by artificial respiration, by compression of thorax, electricity, etc., were made, without success. When Dr. Heuter came to him respiration was very superficial and intermittent, pulse small and frequent, pupils did not act, cornea quite insensible. This was his state half an hour after he was found. The Doctor obtained a pound of blood from a student, defibrinized and injected it at a time when respiratory movements had quite ceased. A vein in the patient's arm was opened, when about two drachms had been injected, but only a few drops of blood escaped. Artificial respiration was kept up while the injection was being made. After half of the blood had been injected blood flowed more freely from the vein. At the end of the injection the pulse was fuller and slower, and natural respiration returned. In half an hour the pupils were sensitive to light and he moved his arm. Recovery was complete on the fourth day.

Case 2.—Dr. Buchser, in the *Medical Record*, reports a case of a German girl, apparently moribund from epistaxis, where he injected three ounces of defibrinated blood in the median cephalic vein, with complete recovery.

Case 3.—Dr. Albert H. Smith, of Philadelphia, reports a case of a patient suffering from an attack of typhoid fever, which ran the ordinary course till the middle of the third week. He then began to bleed freely from the nose and gums, and to pass blood with his urine. All the usual remedies were tried without success, except of a temporary nature. When two and a half ounces of defibrinated blood was transfused, all the oozing from the gums and nose stopped immediately. This is opposed to the opinion of Lesser, in the Boston *Medical Journal*, where he says that "the transfusion of defibrinated blood has no influence in arresting transudation from bleeding surfaces, but is only useful in restoring the nutritive fluid when the drain has been stopped."

It has been proved by experiment that an animal cannot live without the supply of fresh nourishment by the alimentary canal. Blood transfused into the vessels does not take the place of food, and does not prevent an animal which is being starved from dying of inanition. The extra supply of blood corpuscles does not seem to serve as nutriment, but seems rather to a certain extent to be deleterious, by increasing the waste; apparently by using up an additional quantity of oxygen. Blood is regarded as a tissue which is used as the vehicle by which nourishment is carried to the other tissues, perhaps altering the constituents slightly in transit, but is not itself a source of nourishment. Neither is the fibrin used for purposes of nutrition. Even if it were the quantity is so small that it would not be worth while transfusing blood in order that its fibrin might be so used. In a pound of normal blood there is only about fifteen grains of fibrin. Fibrin is further of no essential service in carrying on the respiratory functions. Defibrinated blood is as capable of absorbing oxygen as that containing fibrin. "The one indication

for the use of transfusion is, therefore, deficiency of blood corpuscles, and the deficiency can be as well supplied by defibrinated as by fibrinous blood."

This remark of Professor Pannus, which I have just read, looks very plausible; but then what shall we say to the experiment of Brown-Séquard, who took ninety-five grams of blood from a dog, and replaced it with the same amount of milk. Shortly after the operation there was no trace of milk globules in the blood. Séquard claims the results are the same whether defibrinated blood, normal blood, or milk are used, but in the case of the milk, the quantity that it is necessary to inject is considerably more than in the others. I also find a case of exsanguination reported by J. C. Hutchinson, King's County Hospital, L. I., in which defibrinated blood was tried, and the patient grew worse for one week; when milk was transfused and the patient rapidly improved. The entire report of this case is very interesting, but it is too long to insert here. During the transfusion of the blood, which was done by Aveling's method, one of the joints accidentally became loosened, and a large amount of air entered the vein, but the patient suffered no inconvenience whatever therefrom.

Dr. Hutchinson thinks this danger has been somewhat over-rated, and that in the veins of an extremity certainly there was not the same peril accompanying the introduction of air as in the great veins of the neck or thorax. He also remarks that the milk ought always to be alkaline. It is, however, often acid. He renders it alkaline by adding one ounce of a weak solution of carbonate ammonia to eight ounces of milk. It has been proved by experiment that a dog which has apparently bled to death may be resuscitated by the transfusion of defibrinated blood, as well as by entire blood. The view of Magendie is, therefore, incorrect, that the presence of fibrin is of great importance for the passage of blood through the capillaries.

Experiment shows that when defibrinated blood is injected into the vessels of an animal of the same species the corpuscles are actually transplanted and survive in their new habitation. By using defibrinated blood you avoid the risk of embolism, which is considerable when entire blood is used. Dr Roussel, of Geneva, thinks that the transfused blood should be from a similar origin, *i. e.*, blood from man to man, and venous blood into veins, etc.; also that it should not be altered in any of its constituents, that is, should not be defibrinated. Dr. Martin, of Berlin, advises the transfusion of pure human blood. Dr. Athill, of Dublin, was in favor of using defibrinated blood, to avoid embolism and thrombosis.

I find, on reading up the subject, that most of the medical men advise the use of defibrinated blood, as its transfusion, as I previously stated, is attended with much less risk from embolism and thrombosis. Moreover, the beating up of the blood has a particular advantage in enabling the blood corpuscles to take up plenty of oxygen. The blood should be defibrinized by stirring with a wooden stick, and straining through a handkerchief. Should a second stirring produce more fibrin the straining should be repeated. The blood should stand in a vessel surrounded by water, at a temperature of 100° (38° C.).

The first operations of transfusion were by the direct method. In 1667, Albini, of Naples, performed transfusion, and the following description of the operation is in his own words: "Suppose a gum-elastic tube, about half a metre in length, to be inserted into the carotid artery of a living lamb, and placed in communication with a vein opened in the lady patient." Thus the heart of the lamb was used to propel the blood into the veins of the patient. On the 20th of November, 1669, Sauer and King performed the operation in England, on a man named Arthur Coyn, in the presence of many distinguished and intelligent people. The carotid of the lamb was prepared and a silver tube inserted from which the blood was allowed to flow freely into a vase. In one minute twelve ounces flowed out, and by this means they were able to approximate the quantity which flowed in a given time into the arm of the patient afterward. It is stated that the man derived great benefit from this operation, and that no evil consequences followed.

At the present time Aveling's method or some modification of it is used to a great extent, where it is desired to use pure blood without defibrination, and without doubt it is the simplest and much the best way of performing transfusion, where the blood is not to be defibrinated.

This can be very readily performed with a common Davidson syringe, by removing the pewter ends and substituting glass tubes. If you wish, the tubes can be heated in a spirit lamp, and bent so that they can be inserted more readily.

The india-rubber portion of the apparatus being filled with water, the operation is commenced by compressing the tube on the efferent side and squeezing the bulb; this forces two drachms of water into the afferent vein. Next

shift the hand and compress the tube on the afferent side; then allow the bulb to expand slowly, when blood will be drawn into it from the efferent vein, etc.

When it is desired to use defibrinated blood, which I think is much the safer method, we may proceed as follows: 1st. Expose the vein for about one inch of its course by dividing with scissors a transverse fold of skin pinched up between the fingers. About the vein thus exposed place three ligatures. The one at the distal end of the vein is to prevent loss of blood when the vein is opened, and is to be immediately tied, like an ordinary ligature. The third on the proximal side is to guard against the introduction of air, and is only to be tightened. A valvular opening should now be made in the vein with the scissors, a little to the distal side of the middle ligature. Now we will suppose that the blood meanwhile has been drawn off and defibrinated as I directed before; so we fill a syringe with the blood, insert the nozzle in the opening in the vein, and inject enough to deprive this portion of the vein of any air it may contain; then tighten the middle ligature to secure the vessel to the syringe. Now the proximal ligature must be loosened and the piston of the syringe put in action.

This operation is simplicity itself, and well worth your attention, and if properly carried out it is an impossibility for it to be attended with any great amount of danger to your patient. This is Prof. Heuter's method of operation as described in the *British and Foreign Medico-Surgical Review*, only that he injects into the arteries instead of the veins. I have modified the description to make it apply to them, which you will very readily see only requires that the first ligature should be tied nearest to the heart, instead of on the distal side, as in the veins, and that the point of the syringe be directed toward the periphery instead of toward the heart; also, that the portion of the artery attached to the syringe should be cut out, to avoid aneurism. So you will observe that this method applies equally well, whether the injection be into a vein or an artery. Prof. Heuter thinks that injection into the arteries is far preferable to that in the veins. But it is found that in arterial transfusion a considerably greater amount of pressure is required than in venous transfusion. Thus in anæmia, that exerted by one hand will not suffice, and this is the great objection to its use. I find cases reported, where surgeons have tried arterial tranfusion and could not make a success of the operation on that account, and then resorted to venous transfusion with perfect success. Some have had a special syringe constructed, so that more pressure could be applied.

The most essential advantage of arterial transfusion over venous would seem to consist in the fact that the blood is conveyed to the heart more slowly and equally than in venous transfusion. And as the operation is *usually* resorted to only when life is fast ebbing away, and the heart's action at the lowest, it cannot be a matter of indifference to throw a quantity of blood suddenly into the right side of the heart.

Another advantage of arterial over venous transfusion is, that if a quantity of air gains admission, this does no mischief, but becomes absorbed; whereas, if it were to enter the vein, and ultimately the right side of the heart, it might act very mischievously. Again, the security from *phlebitis* has to be taken into account. A wound of the radial artery is less dangerous than one of the cephalic vein; for secondary hemorrhage from a properly secured artery is a rare occurrence, and it is less dangerous than the suppuration of a venous thrombi.

But whether venous or arterial transfusion is employed is a subordinate matter, as compared with the extension of the practice of the operation as a most powerful weapon in circumstances often regarded as hopeless.

In operating by Aveling's method, or direct transfusion, you will need no instruments besides those usually found in every doctor's pocket-case, except the syringe, which can be obtained at any drug store in the country.

By the indirect method, with defibrinated blood, you will need: (1) A spirit lamp, so arranged as to keep the blood at a temperature of 98° or thereabouts; two or three degrees above or below will do no harm. (2) A thermometer. (3) A good syringe. Any good pewter or hard-rubber syringe will do, provided the piston fits well. (4) A few instruments, such as scissors, forceps, etc. The best way is to set the dish containing the blood inside of another filled partially with water, in which the thermometer is placed, and all arranged or held over the lamp.

The whole operation can be performed with the hypodermic syringe; but that is pretty small, still the idea is worth remembering, as we always have that instrument with us. The idea occurred to me that the hypodermic syringe used by the veterinary surgeon would be very good, on account of its more suitable size.

As good an authority as Brown-Séquard says, that transfusion succeeds in animals when the blood made use of comes from a species of ani-

mal different from that of the one under experiment. But most writers on this subject maintain that the blood of a different species is very deleterious to the human system, if not actually poisonous, often producing dizziness, headache, cloudy urine, etc.

Human blood is far the best that can be used, and it certainly is always readily obtainable.

The danger of transfusion from one animal to another of a different species is due to the difference in the size of the corpuscles, thus stopping up the capillaries and obliterating them, causing grave accidents.

As to the quantity necessary in each case, no rule can be laid down. It will vary from one half ounce to twelve. It will be necessary to consider the condition of the patient, also to watch the effect of the operation as you proceed. Many severe cases are reported where only two, three or four ounces have been injected, and the patients recovered speedily without a repetition of the operation.

One would be naturally led to suppose that where one person gave a portion of his blood to another by transfusion, there would be no more danger to the donor than in any ordinary bleeding. But I find cases of death reported, two occurring in the last year, and the cases were all said to be conducted with skill and care.

Two doctors at St. Petersburg, appreciating that the great obstacle to successful transfusion was the coagulation of the blood transfused and the formation of thrombi, have instituted experiments to ascertain how far this may be avoided by employing the vessel of a living animal for a canula. For this purpose a portion of the jugular or femoral vessels was cut from a living animal and passed into a glass tube a little shorter than the excised portion of the blood vessel, the ends of which were secured to the tube by silk threads. As a means of comparison a similar glass tube was employed without having the blood vessel attached to it. Another plan was to dissect out a large portion of the blood vessel, and only to arm the free ends with the glass tube. This last plan being most suitable when venous blood is employed. The experiments showed that while blood on entering the simple glass tube immediately formed small coagula, that which passed through the living canula remained fluid; provided that no lesion of the inner wall had taken place. The blood vessels thus removed from the animals retained their power of maintaining the fluidity of the blood for one hour and a half. During the experiment the stream was often interrupted and then allowed to flow again, without any coagulation being induced; while the whole calibre of the glass tube became blocked up in seven minutes."—*Med. and Surg. Reporter, March 3d*, 1877.

This last idea I introduce thinking that it may suggest some idea that may be of service. But what I have endeavored to impress upon the practitioner's mind all the way through this article, is the comparative simplicity of this operation, and that all the necessary instruments for the successful performance of the same can be found in every wide-awake practitioner's office. And further that we have in this operation a most powerful weapon in circumstances often regarded as hopeless.

Hospital Reports.

NEW HAVEN (CONN.) GENERAL HOSPITAL.

Prevailing Diseases and their Treatment, with Report of Cases.

Our hospital is, as you know, one of the smaller hospitals, ranking with those at Hartford, Worcester, etc. The average number of patients varies between 75 and 80. Not being an endowed institution, it has to depend largely for its support on the board of the patients. These may be divided into four classes, *i. e.*, soldier, sailor, town, and self-paying patients.

The most common diseases which are met with are these: (1) phthisis (chronic catarrhal pneumonia), forming a large proportion of all the medical cases, and presenting no peculiarities whatever.

The next most common are cases of alcoholism, of which we have a large number each year, and in whose treatment we have been very successful.

Next to these come cases of intermittent fever, which are very common, the disease being apparently contracted in this neighborhood. It is not an unfrequent occurrence to see persons who have never been outside of this State having their regular morning shake.

Next in point of numbers would come the confinement cases, and cases of chronic rheumatism.

Of the surgical cases, those of fracture are by far the most common. Then come cases of coxæ morbus; of these we have had a number of chronic cases, which have been operated upon again and again without any permanent benefit. Cases of stricture are quite common, but so far they have presented little of interest.

There were three cases of ovarian tumors, in which operations (without Lister) met with great success. One of these cases was most unpromising, but the result was highly satisfactory.

So far as treatment goes, it is very difficult to say really how a given case would be treated, for the treatment depends entirely upon the visiting

physician, and so the cases are treated in various ways.

As a rule the treatment is simple, single drugs being used in most cases, and not elaborate and intricate prescriptions.

The cases, so far as I have seen, do remarkably well.

In cases of acute rheumatism the routine treatment is—

℞. Salicine, gr. xx.
In wafers every two hours,

combined with external bathing of the parts with an alkaline wash, and wrapping the afflicted joints in cotton batting.

The salicine has been found to answer all the purposes of salicylic acid, and is much less irritating to the stomach and less likely to produce nausea, and furthermore, is very much cheaper.

As to house prescriptions we have very few, but of them one is used almost constantly as a stimulant and febrifuge:—

℞.	Camphoræ,	℈ j	
	Ammon. carb.,	ʒ j	
	Muc. acaciæ,	ʒ j	
	Aquæ,	℥ j.	M.

Sig.—ʒ ss every two hours.

The lictus morphiæ is also much used. The formula for it is as follows:—

℞.	Morphia sulph.	gr. j	
	Spts. chloroform,	ʒ j	
	Muc. gm. acaciæ,	ʒ j	
	Syr. tolut. q.s. ut. ft.	ʒ ijss.	M.

A favorite diarrhœa mixture is as follows:—

℞.	Tr. opii,	
	Tr. capsici,	
	Tr. rhei. aromat.,	
	Spts. camphoræ,	
	Spts. menth. pip.,	āā.

We have of late used quite extensively codeia, as a substitute for morphia, and with very good results. It is given in capsules, and can be taken by those who are unable to take morphia in any form.

It is, of course, no new thing to give hypodermic injections of water for pain; but a more curious case than this came to our notice lately. A weak, anæmic woman, forty-five years of age, with chronic gastritis and several other chronic affections, had been in the habit of taking morphia in the form of "sleeping drops," and for the first few nights she was given morphia. But after this we had a bottle carefully labeled "sleeping drops," and filled with water. Of this she took a drachm at bedtime. At first she complained that the medicine was too strong and made her head feel badly the next day; so that the dose was reduced one half. This she took for nearly a month, sleeping nicely when she did take it, and not sleeping at all when it was withheld.

Our treatment of acute pulmonary diseases consists almost entirely in the external application of large and frequently renewed flaxseed poultices, covering the back and front of the chest.

The general treatment of all the diseases here is almost entirely symptomatic.

As regards bedding, we have nothing peculiar, with the exception of a water bed, which I believe was manufactured here. It consists of a series of separate rubber bags, long and narrow, which are placed crosswise of the bed, and can be filled just as the case requires. This, when nearly filled, makes a very comfortable bed, and the pressure of any part of it can easily be regulated.

In the surgical wards few new inventions are in use. The plaster-of-Paris bandages for fractures are largely used, and especially the Bavarian splint. In applying this we have found that the two layers of flannel, with the plaster between, does not make a stiff enough bandage for fractures, so now we place five or six layers of crinoline, carefully cut in the shape of the limb, between the two coverings, and firmly imbed them in the plaster. In this way we get a very reliable splint.

In the dressing of ulcers we use largely a mixture of one part of iodoform and three parts clay; this makes an excellent dressing, and has been found by us to be superior to simple iodoform. Salicylic cotton and vaseline have been largely used, when partial Lister dressings have been desired, with very good results.

A saturated solution of tannin in collodion is used as an application to check hemorrhage, as in cases of carcinoma uteri, etc.

Interesting Cases.

John O'W., aged 49 years, came to the hospital with a note from a doctor who wished us to operate for strangulated hernia. The man was apparently much prostrated and walked with great difficulty. On inquiring into the history of the case we learned that Sunday before entrance, while sitting on a board pile, he fell and struck on the sharp edge of a plank, receiving the full force of the fall on his scrotum. This immediately began to swell and to be discolored. On entrance, the scrotum was fully the size of a child's head, greatly discolored and cold. There seemed to be a partial line of demarcation formed.

The scrotum was carefully washed, wrapped in cotton and elevated, and stimulants and tonics given. The next day the line seemed to have disappeared, the scrotum was warm, and all seemed favorable. In a day or two the scrotum became cold again, and the whole lower part began to slough. Charcoal poultices were applied and the stimulants increased, the man's strength being quite good. In three days the slough came away, leaving both testicles entirely exposed. A most obstinate diarrhœa set in, but was finally controlled by suppositories of tannin and opium. The edges of the wound began to granulate, and now the entire scrotum is nearly replaced and the patient is in very good condition.

Henry B., forty-eight years old, married, and a cook by trade, entered hospital for paralysis, July 18th, 1879. Improved rapidly until August 20th, when suddenly the patient began to complain of severe headache, with loss of appetite, and constipation. At 2 A.M. of the 21st he was found sitting upon the bed and complaining greatly of those severe pains in his head. Temperature found to be 96° in axilla, pulse soft and compressible, 66 per minute, heart's action weak

and irregular. Patient sank rapidly, becoming too weak to sit up, and complained of vertigo if his head was raised in the least. The tongue soon became paralyzed, so that speech was impossible and swallowing performed with great difficulty. Great pain in spine and through abdomen. Entire spine tender on pressure and pain greatly increased by motion. Respiration at times rapid and shallow, but generally slow and irregular, often not more than three per minute by actual count. Whisky, ℥ j, with aqua ammonia, gtt. xx, was given at first, followed by ℥ ss dose of first with same dose of ammonia every half hour, later every hour. Heart's action much improved; frequent spasmodic attacks, with great pain, during which muscles were in a state of tetanic contraction, and once opisthotonos to a marked degree was produced.

At 7.30 A.M. twenty grains of quinia was given, and later a blister was applied to the nucha, after which the patient gradually regained power of speech.

During the day was quite comfortable. At 6 P.M. breathing began to grow irregular and infrequent, as during preceding night. At 7 P.M. was attacked with violent nausea and vomiting, followed by fainting fits. Subcutaneous injections of dilute aq. ammonia and whisky were given; patient recovered some and slept the rest of the night. The next night the patient had a similar attack, but with this there was slight delirium. The temperature was remarkably low, but the body throughout the attacks felt warm, and was at times covered with perspiration. Hyperæsthesia over abdomen and legs below the knees were insensible to pain, and during one attack, the arm also. Constant rolling of the head on the pillow.

On the 30th instant patient had entirely recovered, and nothing of this kind ever occurred again during his stay in the hospital.

Charles G., twenty-four years; Irish. Cause of death, acute catarrhal pneumonia. Autopsy by Dr. W. H. Carmalt. This case presented one feature which was to us very interesting, *i.e.*, the kidneys; these were united by their inferior extremities, in the form of a horseshoe, riding the spine like a saddle. The renal arteries arose from the aorta by a common trunk or axis, about one inch in length; this trunk divided in two branches, which entered the kidneys at each hilus. The ureters arose from the anterior and inferior portion of pelvis, and passed downward in front.

The substance of the kidney was uniformly healthy. No urinary symptoms during life.

Isaac Pardu, sixty years; American. Pernicious anæmia. Began to lose flesh and strength gradually two years before entrance, without any apparent cause. He had no sickness aside from this. This condition of things continued up to the time of his death. His appetite was enormous. Urine low specific gravity, but no sugar or albumen.

The post-mortem revealed a curious condition of things. There was a general softened condition of the whole bony system; both humeri were broken; the ribs were so soft that the least pressure caused a fracture The blood was thin and pink in color, and did not coagulate. The muscular tissues were very friable and pale in color.

Aside from this nothing was found. The thoracic duct was pervious.

Some little time before entrance he received a blow on the head, which caused a considerable swelling; this proved to be a hæmatoma, which, by its pressure, and by the softened condition of the bones of the skull, had eaten its way through both tables and was pressing directly on the dura mater.

Editorial Department.

Periscope.

Treatment of Scarlet Fever by Warm Baths.

The following communication from W. Vawdrey Lush, M.D., physician to the Dorset County Hospital, appeared in *The Lancet*, August 14th, 1880:—

In December, 1869, while we were experiencing a very severe epidemic of scarlet fever, there appeared in *The Lancet* a reprint of a letter by Dr. Charles T. Thompson, strongly advocating the use of warm baths in this disease, and stating that he had pursued the practice for fifteen years, and had never lost a patient.

In consequence of this communication, I commenced this practice ten years ago, and have followed it from that time to the present. At first I order the patient to have three warm baths daily, to be kept in from three to five minutes, rapidly dried, wrapped in a blanket, and returned to bed. As the disease subsides, I reduce the baths to two or only one daily. I find that—1st, it brings out the rash; 2d, reduces the temperature; 3d, soothes the patient; and when this treatment has been adopted at the onset, I have as yet not lost a single patient.

In one case the warm bath was objected to till the child had been ill some days, and this case, and this alone, proved fatal.

My friend, Dr. Alfred Hollis, of Freshwater, has told me of the great comfort he himself experienced from warm bathing when suffering from the disease; and, of course, in the treatment neither medicine proper nor good nursing is precluded.

Some of my readers may recollect a case of smallpox published by the late Dr. Stokes, of Dublin, where the warm bath proved singularly beneficial, and who doubted not that the mortality in smallpox hospitals would be greatly diminished by the use of the bath. The case I

refer to was that of a medical student, in which "the pustulation was almost universally confluent; the purulent matter highly putrescent; the hemorrhagic state developed, the body one universal ulcerous sore, and the blackness of the worst purpura developed; the odor of an intensely pungent and offensive character, which seemed to pass through the bystander like a sword. Stimulants alone, freely and constantly employed, seemed to preserve the patient alive. The pulse was rapid, weak, and intermittent, and for several days life was despaired of. At this juncture Dr. Stokes happened to describe the case to his colleague, Mr. Smyly, who suggested the trial of the warm bath. Pillows were adjusted in one, the patient placed in it, and the effect was instantaneous and marvelous. The delirium immediately ceased. The patient exclaimed, 'I am in heaven! I am in heaven! Why didn't you do this before?' He was kept at least seven hours in the bath, brandy being freely administered, and removed to bed. The bath was repeated next day, after which he fell for the first time into a tranquil slumber. From this time recovery was progressive."

This may seem a digression; but the treatment of another of the exanthemata by similar means is not inapposite.

My ten years added to Dr. Thompson's fifteen make twenty-five years' experience of a treatment which I can confidently and heartily recommend.

Chloroform in the Treatment of Puerperal Convulsions.

Dr. K. N. Fenwick, of Kingston, Ont., reports the following interesting case in the *Canada Lancet*, September 1st, 1880:—

Mrs. L., aged twenty-one, primipara, dressmaker, had always enjoyed good health, and, until a few weeks before delivery had been very well, with the exception of occasional attacks of facial neuralgia. During the last few weeks of her pregnancy she had swelling of the face and feet. On the afternoon of the 10th of September, 1879, she complained of very severe headache, of a different character from her former neuralgia, accompanied by a slight diarrhœa. I was first called to see her upon the same day, about 9.30 P.M., when she had a convulsion. She had slight regular pains in the back, and on examining the os, found it hardly dilated enough to admit the index finger, the head presenting in a roomy pelvis. I made her inhale chloroform with the effect of arresting the convulsions, and then gave potassium bromide, grs. xv, every hour, with the effect of warding off the attacks until 5 A.M.

As the convulsions now returned with greater frequency, the os still undilated any more than on my first examination, and the patient becoming comatose, on consultation with Dr. Lavell, decided to deliver at once. I then directed a stream of hot water against the os, by means of a ball syringe, and began to forcibly dilate the os with the fingers, repeating the hot water injections, and carefully dilating the os until in less than half an hour it was fully open. I then ruptured the membranes, gave a dose of ergot, drew off a few ounces of highly albuminous urine, applied the forceps and delivered a healthy living child. Chloroform was administered during the forcible dilatation and application of forceps, with the effect of modifying, though not preventing the convulsions. The uterus contracted well and no hemorrhage occurred. She had two convulsions after delivery, but they were slight, were at once checked by chloroform, and never returned. Gave chloral, grs. xxx, by rectum, every four hours.

At 9 P.M. temperature was 100° F. Though insensible she took beef tea from a spoon with avidity. I then gave a diuretic mixture of acetate of potash, digitalis and broom. Sensibility slowly and gradually returned, until, on the 13th, she asked to see some of the family. From this time her recovery was rapid, and to-day (June 8th, 1880,) both mother and child are in perfect health.

The interesting point about the case was the rapidity with which the os uteri became dilated under the influence of the hot water injections, and digital manipulation. Some authorities, such as Leishman, are averse to forcible dilatation during puerperal convulsions, on the ground that it increases the attacks; but there can be little doubt, from the duration of the comatose symptoms, that an expectant treatment in this case would have ended fatally.

Secondary Syphilitic Epilepsy.

M. Fournier states, in *Annales de Dermatologie et de Syphiligraphie*, Nos. 1 and 2, 1880, that his object in publishing the following cases is to establish the fact that certain symptoms of an epileptic character do sometimes occur during the secondary stage of syphilis, and especially during the early part of this stage. The symptoms are very different from those which occur during the tertiary period, as regards significance, evolution, and gravity.

CASE 1.—A young woman of fair constitution and previous health, was admitted into the Lourcine Hospital on account of secondary lesions of the vulva and mouth. Some weeks later there occurred a severe outbreak of cutaneous syphilis, with enlargement of the glands, affections of the periosteum, headache, insomnia, etc. Suddenly there appeared a series of peculiar attacks, some of which were witnessed by M. Fournier, and of which he gives the following description. "The countenance suddenly assumes an extraordinary indescribably stupid expression. The head is turned from the left side. The left upper extremity is suddenly raised toward the face, the wrist and fingers being strongly flexed. The lower limb of the same side is forcibly extended. The whole body, in short, is rotated from right to left. The phenomenon lasts a few seconds; then violent clonic spasms affect the left upper limb. Finally, the patient for some minutes longer remains stupid, stunned, and unconscious, and the fit is at an end." During several days these fits were repeated, but very soon there appeared attacks of general convulsive epilepsy, in every respect resembling the *haut mal* There were a large number of such attacks during the first month. In the second month there were

five fits, and only two during the next two months. Under energetic specific treatment the cutaneous and other lesions disappeared; the epileptic attacks also ceased and did not return.

Case 2.—A strong young woman, of good constitution, was found on admission to be suffering from chancrous induration of the labium, with inguinal adenopathy, roseola, lesions of the tonsils, and general analgesia of the skin and mucous membranes. She had not undergone any treatment previously. Some days after admission the patient was seized during the night with a violent convulsive attack. She was found to be unconscious, foaming at the mouth, and in a state of convulsion like that of the *haut mal.* After the fit she fell into a deep sleep. A second fit occurred about a quarter of an hour later, followed by involuntary evacuation of the bladder, and an almost comatose condition, which lasted until the following morning. The next day M. Fournier found the patient somnolent, and incapable of answering questions. The excitement of the examination, however, brought on another fit, which was carefully observed by M. Fournier, and found to present all the characters of ordinary epilepsy. The next day consciousness was fully regained, and the patient then affirmed that she had never before suffered from any attack of the kind, nor from any nervous affection whatever. There was no family history of any nervous disorder. Minute examination failed to reveal any other cause than syphilis. Protoiodide of mercury had already been prescribed, and was continued without any other medication; the effect being that the roseola and other signs of syphilis quickly disappeared, and the fits did not return. Three months later the patient was discharged in good health, but was seen on several occasions during a year afterwards for various slight syphilitic symptoms. There had been no return of the epileptic seizures.

Case 3.—A robust young man, aged 25, of nervous temperament, contracted syphilis in 1867. In the secondary period, between the third and sixth months, he had three well-marked attacks of epilepsy. There was no hereditary tendency, and no other cause except syphilis could be ascertained. Under specific treatment the external signs of syphilis disappeared, and there was no repetition of the epileptic attacks. Thirteen years have now passed without any reappearance. These three cases, with about a dozen others observed by the author, prove, in M. Fournier's opinion, that symptoms of the nature of epilepsy may occur during the first few months of syphilis. M. Fournier looks upon this secondary epilepsy as being a *specific neurosis;* that is to say, it consists of a group of morbid symptoms developed under a specific influence, but occurring probably without any lesion of the nervous centres.

Traumatic Tetanus Treated by Stretching the Median Nerve.

The following case, which is reported in the *Medical Times and Gazette*, August 21st, 1880, occured in the Seamen's Hospital, Greenwich, under the care of Mr. W. Johnson Smith:—

R. B., aged fifty-four, a spare and feeble man, was admitted on the morning of January 23d, 1880, with injuries to the right forearm and left thigh, caused by the sinking of the roots and of the lower portion of the trunk of an old elm tree which he had been attempting, at the bottom of a deep excavation, to undermine. On examination there was found a simple transverse fracture of the shaft of the left femur, near the junction of the lower with the middle third. There was marked over-riding of the upper fragment, and also considerable eversion of the foot. On the posterior surface of the left forearm was an extensive oval wound measuring eight inches in the vertical direction and three inches from side to side. Both the skin and deep fasciæ had been torn through, and the tendons of the extensor muscles were freely exposed. The skin beyond the margins of the open wound was extensively undermined, and much of the raw surface was covered by damp earth. No portion of either of the bones seemed to have been stripped of soft covering.

The injured lower limb on the left side was suspended in Hodgen's apparatus, and it was retained in this until February 23d.

On the third day after admission the right forearm, which had been kept in a constant bath containing a very weak solution of carbolic acid, became the seat of suppurative cellulitis, which spread rapidly to the front of the limb and upward beyond the elbow. Free incisions were made on the following day in various parts of the swollen extremity, and one of these was carried through a gangrenous patch of skin in front of the elbow and to the inner side of the tendon of the biceps.

During the first week of February, while the swelling of the forearm was subsiding and an extensive granulating surface was being rapidly cleared of large masses of slough, the patient, whose general health had remained good, complained very much of painful contractions of the flexor muscles of the forearm and of forcible flexion of the fingers, the tips of which were from time to time tightly pressed into the palm.

This condition of spasm increased very much in severity during the second week, and prevented the patient from sleeping. On February 12th, after a sudden rise in his temperature, he complained of stiff neck and difficulty in swallowing. On the following morning there was well marked risus sardonicus; the lower jaw was tightly set, the abdominal muscles and those of the lower extremities were from time to time very hard, and there was acute pain in the epigastrium. At noon, ether having been administered, the median nerve was exposed in the middle of the arm, and then, after it had been compressed, was forcibly dragged both downward and upward. The wound was made under the spray (carbolic acid), and dressed with gauze.

After the effects of the anæsthetic had passed off, the patient found that the right forearm was quite free from pain, and that the spasm of the flexor muscles had ceased. The fingers were quite lax, and could be extended without difficulty. This improvement seemed to be permanent, as no recurrence of the involuntary mus-

cular contraction was complained of during the slow healing of the extensive open surface on the back of the limb. On the evening of the 13th (the date of operation) he still complained of difficulty of swallowing and of pain and stiffness in the abdominal muscles, but in the course of the two following days these symptoms gradually subsided. In consequence of retarded union at the seat of fracture of the left femur, the patient was unable to leave his bed before the end of April. He was discharged as convalescent on May 10th, being then able to walk with the support of a stout stick, and with the wound of the forearm almost quite closed, the functions of this extremity, however, being much impaired through the extent of the cicatrization and consequent constriction of all the soft parts.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——"Pregnancy Vomiting," is the title of a pamphlet by J. Marion Sims, M.D., reprinted from the *Archives of Medicine*, June, 1880.

——A reprint from the Archives of Ophthalmology, June, 1880, contains a paper on the use of "Salicylate of Sodium in the Treatment of Iritis," by Julian J. Chisolm, M.D.

——Dr. Webb J. Kelly, of Galion, Ohio, sends us a pamphlet containing "A Summary of Eight Hundred Obstetrical Cases," occurring in the practice of H. R. Kelly, M.D., Galion, Ohio.

——"The Mechanical Treatment of Cystocele and Procidentia Uteri," is the subject of a paper by Eugene C. Gehrung, M.D., of St. Louis, which comes to us in the form of a reprint from the *American Journal of Obstetrics and Diseases of Women*, for July, 1880.

——A reprint from *Transactions Missouri State Medical Society*, 1880, contains remarks on "Abdominal Surgery, Cyst of Broad Ligament, Laparotomy, Recovery," by F. J. Lutz, A.M., M.D., of St. Louis, Mo.

BOOK NOTICES.

What to Do First, in Accidents or Poisoning. By Charles W. Dulles, M.D., Surgical Registrar to the Hospital of the University of Pennsylvania, etc. Philadelphia, Presley Blakiston, 1012 Walnut Street, 1880. Cloth, 16mo. pp. 64. Price 50 cents.

The title of this work sufficiently indicates its character. It is intended to serve as a guide to those who may happen to be present at an accident, and to point out to them what to do until the arrival of a physician. The usefulness of a work of this kind can never be over-estimated, for a certain amount of knowledge of what is needed in an emergency will keep its possessor cool, where ignorance will only produce confusion. Only accidents of common occurrence, such as drowning, hanging, suffocation with noxious gases, fits, freezing, burns, sunstroke, sprains, fractures and dislocations, wounds of various kinds, hemorrhage, railroad and machinery accidents, with transportation of injured persons, and poisoning are treated of. The book is furnished with numerous cuts and its value is increased by the addition of a complete index. We cheerfully recommend this little work to the intelligent public.

The Pathology, Diagnosis, and Treatment of Diseases of Women, including the Diagnosis of Pregnancy. By Graily Hewitt, M.D., London, F.R.C.P.; Professor of Midwifery and Diseases of Women, University College, and Obstetric Physician to the Hospital, etc., etc. Third American, from the Third London Edition, Revised and Enlarged. With one hundred and thirty-two illustrations. Philadelphia, Lindsay & Blakiston, 1880. 8vo., pp. 751. Price, cloth, $4.00; leather, $5.00.

The author informs us, in the preface to this edition, that while the former editions contained, the first, mainly a summary and a criticism of the then existing knowledge on the subject of the diseases of women, and the second, numerous pictorial illustrations of his own observations, with suggestions of an improved system of uterine pathology, this, the third edition, contains certain generalizations on the important question of the pathology of diseases of the uterus which have forced themselves on his attention in the course of several years' experience, and which involve the adoption of views in reference to the pathology and treatment of those diseases which are new, as compared with those embodied in the early editions of this work. The results of a series of observations made by the author in the University College Hospital, during a period of four years, are given in support of the doctrines advanced. The cases are carefully tabulated, and long histories of the same dispensed with. The various subjects treated of are systematically arranged, and, it seems to us, exceedingly well elucidated, both as regards diagnosis and treatment, and although several excellent works on gynæcology have recently been published, we feel sure that no one will consider this addition to the literature as superfluous. The book is gotten up in the usual elegant style of the publishers.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE INVIOLABILITY OF PROFESSIONAL COMMUNICATIONS.

It is indispensable to the proper treatment of a case that the attending physician be made acquainted with its history. This frequently involves disclosures on the part of the patient which no other consideration than the risk of his own life would induce him to make. Not rarely, they are of such a nature that they would not only blast his reputation were they generally known, but would criminate him, were they made in a court of justice. As such, the law would sanction his refusal to make them, even in the pursuit of the ends of public justice, and to secure the conviction of dangerous malefactors. Is not the physician bound, by every tie of honor and duty, to refuse to reveal such professional confidences, and should not the law protect him to the utmost in this refusal?

We believe that it should, in the fullest measure. Yet the matter is not decided in many States. There are still instances, from time to time, where a physician is called to the witness stand, and the court permits him to be cross-questioned as to professional confidences, and will not admit the plea that he is not permitted to repeat them. In some States, indeed, we believe it has been decided that the physician must testify to the best of his knowledge and belief, or expose himself to the penalties of contempt of court. The law of New York State is more enlightened on this subject. It is given as a sort of *obiter dictum*, in an address on malpractice, last winter, by GEORGE CLINTON, L.L.D. late Chief Justice of the Supreme Court of the City of Buffalo.

That learned authority justly states that at common law the disclosures of the patient to his physician are not sacred; and the physician, as a witness, is compelled to testify as to the communications of the patient, however necessary to enable him to judge and prescribe. The Revised Statutes of New York contain an enactment, which, as re-enacted by the code, with some change of phraseology, reads thus: "A person duly authorized to practice physic or surgery shall not be allowed to disclose any information which he has acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity." (Code, § 832). This language is extremely broad and comprehensive. Judge CLINTON believes that the courts will construe it as applying only to information derived from the patient, and apply it only to actions and indictments in which he is directly interested. Surely, if a man be injured by another, the physician who attended him must be admitted, on the trial of the injurer, to prove all of the injured man's disclosures, and his bodily condition and symptoms. In Johnson *vs.* Johnson (4 Paige, 460), Chancellor Walworth held that the testimony of the physician was admissible, he only objecting. But upon the reversal of that case in the Court for the Correction of Errors, Chief Justice Savage maintained what is apparently the true doctrine, that the secrecy of the physician is solely the patient's privilege, and that the physician cannot testify as to the facts within the Statute prohibition unless the patient grants permission. This view of the

case recommends itself to common sense as well as to sound law.

The New York Statutes not only protect the physician if he declines to testify without the patient's consent, but they also are framed to punish the physician should he make damaging disclosures without the patient's permission. This is as it should be, for if honor does not seal the medical attendant's lips, then it is well that the law shall clasp its iron padlock on them.

It were highly desirable that these questions were settled in all the States. The welfare of the profession is so closely interested that medical societies generally should take up the subject and have Acts passed similar to those which exist in New York, and which, so far as we can learn, have worked very well. The field of medico-legal studies might well be extended to the more exact defining of the relations of physicians to their patients on the one hand, and to courts of justice on the other.

Notes and Comments.

Therapeutical Notes.

SALICYLATED CAMPHOR IN PHAGEDÆNIC ULCERATION.

In the treatment of this form of ulceration, Dr. Lajoue, according to *La France Médicale*, employs an ointment composed as follows: camphor, 10 grams; salicylic acid, 10 grams. These are mixed, and then there is added, alcohol (at 90°C.), 10 drops; vaseline, 10 grams; paraffine, 25 grams. This makes a consistent ointment, which is put upon the wounds.

PEPTOGENIC ELIXIR.

In cases of dyspepsia where the indications are to favor the secretion of gastric juice, and to introduce peptogenic substances into the stomach, Dr. Dujardin-Beaumetz employs an elixir, the formula of which, as published in *La France Médicale*, is as follows:—dextrine, 10 parts; rum, 20 parts; syrup, 60; water, 120. This elixir has a very agreeable taste, and is of service in the cure of atonic and putrid dyspepsia.

Bathing after Meals.

Two cases carefully studied by Dr. Naegli, and published in the *Swiss Medical Journal*, afford a striking illustration of the old warning not to bathe with a full stomach. The cases were those of two persons who died when bathing, and in whom the post-mortem examinations revealed similar appearances, affording a certain evidence that death was due to the fullness of the stomach with food at the period of immersion. The first is the case of a lad, fourteen years old, who, on a holiday, after regaling himself with bread and sausages, and a glass of beer, went into the river, with a comrade, for a swim, in the evening, and was swimming gaily ahead of his friends, when suddenly, uttering only an indistinct sound, he sank below the surface; assistance was quickly at hand, and he was drawn out within three or four minutes after he had sunk. The physician was at hand at once, and the fullest hopes were entertained of being able to restore life, as the period of immersion had been so short and the heart could still be heard to beat. Artificial respiration was at once employed, but without any success; then, without much delay, tracheotomy was had recourse to; but on opening the larynx, instead of air rushing out with the well-known sound, a stream of fluid food escaped from the wound. Every means was now attempted to remove by suction these foreign substances from the obstructed trachea, but uselessly; and, in spite of all endeavors, the lad could not be restored to life. A post-mortem examination showed but few of the usual signs of suffocation from drowning, but the trachea was injected rosy red, contained small quantities of food, and the larger bronchi and bronchioles showed, in their lumen, small pieces of potato entangled and obstructed; even sections in the periphery of the congested lung showed the remains of food in the larger bronchioles. The second case was one of a student aged eighteen, who went to bathe after an evening meal consisting of cheese, bread, and beer; and soon after entering the bath, sank suddenly, uttering a dull, gurgling sound, and was only recovered from the water a quarter of an hour afterwards, being then quite dead and incapable of being restored to life. A post-mortem examination showed, again, the larynx and air-tubes full of fluid contents of the stomach, the bronchi and larger bronchioles extending into the lung being obstructed by small particles of cheese. These two post-mortem examinations show that both of these unfortunate persons were suffocated by the food which had passed into their trachea and lungs when sinking; the explanation appears to be that the bathers had entered the water with a full stomach; that the pressure of the water on the abdomen, and the efforts in swimming, which not unfrequently pro-

duce in swimmers a slight feeling of sea-sickness, had induced nausea and vomiting. This had suddenly taken away their strength; they had sunk under the water, and in sinking had drawn in the food thrown up from the stomach and water into the larynx: the trachea had thus become obstructed by food; so that, even in the case of immediate help, which in this case was at hand, recovery could not be effected. The warning "not to bathe when the stomach is full of food" is certainly very strongly emphasized in these carefully observed and conclusive cases.

Color-Blindness.

The *British Medical Journal*, August 21, 1880, informs us that Dr. Favre, of Lyons, recently read a paper of much general interest on the relations of color-blindness, at the Paris Academy of Medicine. He has examined more than ten thousand male adults, by different methods, and has discovered that more than ten per cent. of them were not capable of distinguishing one or several of the five elementary colors; he has also met with two cases of serious and comparatively dangerous Daltonism, and eight cases of injurious or troublesome chromatopseudopsia. The examinations made in reference to railroads, the army and navy, would be insufficient if it were necessary to determine by the examination of the sense of color the aptitude of individuals for those commercial or industrial pursuits which involve the examination of colored objects. It would, perhaps, be necessary, in that case, to examine two hundred or three hundred shades and colors. Among the very numerous mistakes quoted by Dr. Favre, several were made by woolen-drapers, tailors, jewelers, weavers, and dyers. An exact knowledge of colors is necessary to magistrates, and is indispensable to experts, who should have a very acute sense of color. Dr. Favre quotes instances in which M. Ferraud, an analytical chemist, formerly assistant to M. Chevreul at the Gobelins, has been able to rectify in his reports very important errors committed with regard to colors in the description of inculpating objects in criminal cases. The reports had been drawn up by rural constables, policemen, or other agents of the authority. Chemists, botanists, and micrographists are often very much troubled. General practitioners and chemists suffering from dyschromatopsia know very well generally how to manage matters; they know how to make use of the persons whose sight is normal. M. Favre has sought out the cases of dyschromatopsia which have been publicly recorded, and especially those which have come before the tribunals of justice. Discussions and quarrels have occurred in schools; some cases have been brought before the tribunals. The examination of the color-sense of the persons at issue would be sufficient to enlighten the judges. The errors of Daltonians with regard to postage-stamps have been so frequent as to determine the French authorities to increase the diameter of the figures, and to exact an examination in colors from their staff. All these circumstances go to prove that such an examination should be more generally resorted to, and that the color-blind should be made responsible to the law for their mistakes; and, as Daltonism can for the most part be cured by exercise, the legislation required would certainly become an excellent therapeutic agent. Those persons who were past cure would be warned that they must abstain from giving any judgments on colored objects.

Diseases of the Uveal Tract.

In an able paper in Knapp's *Archives of Ophthalmology*, vol. x, No. 2, June, 1880, Dr. Max Knies relates the clinical history and post-mortem examination of a case of double serous iritis. The patient was aged nineteen, and while under treatment died somewhat suddenly, from croupous laryngitis complicated with pneumonia. The eyes were removed shortly after death and preserved in Müller's fluid, and when sufficiently hardened were submitted to very careful microscopic examination. The centre of inflammation appeared to lie at the attachment of the iris and ciliary muscle, and in the adjoining portions of the ciliary body. Bowman's membrane was thickened, which the author believes points to the existence of 'a process located in the anterior part of the globe' and connected with increased tissue changes. In the formation of the patches characteristic of this affection the membrane of Descemet is probably quite passive. A very important point brought to light by the post-mortem examination was the pronounced cellular infiltration of the pia sheath of pia mater from the optic disc to the chiasma; hence, the author concludes that serous iritis is continuous and connected in both eyes. This condition of the optic nerve he regards as independent of any cerebral affection, as peculiar to iritis serosa, and as forming the connection between the affection of one eye and of the other. Iritis serosa, according to the author, is essentially an affection of the whole globe, with the exception of the lens, which,

however, frequently becomes affected in later stages of the disease. The seat of the inflammation is primarily in the uvea; but its continuous propagation can be demonstrated through the choroid, papilla, and optic nerve, along the chiasma, to the other eye, a process which hitherto has only been known to exist in certain gliomata. Iritis serosa has this in common with glaucoma, that the region of insertion of the iris participates in the affection, and that great variations of tension are often observed. Accurately speaking, iritis serosa is really an uveitis serosa in the widest sense of the word, in opposition to the purulent form; between these, however, only quantitative differences exist. The anatomical proof of a direct continuity in the inflammation of both eyes, as established by post-mortem examination in this case, is of fundamental importance, in explaining the origin of sympathetic affections. It would rehabilitate Mackenzie's theory of the propagation of sympathetic ophthalmia by means of the optic nerves through the chiasma. Should subsequent researches demonstrate the correctness of the inferences drawn from this case, it would no longer be possible to refuse unconditionally to accept a continuity in other double uveal affections, which begin with neuritis and do not occur simultaneously.

The Pathology of Lead Palsy.

Zunker relates, in *Zeitschrift für Klinische Medicin*, the case of a painter who suffered from lead colic and paralysis, advanced phthisis, and chronic renal disease. He had marked blue line on gums, double paralysis and atrophy of the extensors of the hand and fingers (the supinators excepted), atrophy of the thenar, hypothenar, and interosseus muscles, paralysis of the extensores digit., pedis, and peronii on the left, paresis of these muscles on the right side, no alterations of sensation, bladder and rectum intact, mind unaffected, the paralyzed muscles not excited by either current, degenerative reaction of the paretic leg muscles on the right side. He found, post-mortem, corpora amylacea in the anterior and postal spinal nerve roots, as well as on the cord itself, especially in the posterior columns. The fibres of the nerve roots were only smaller than normal. In the cervical region the gray matter was of a normal shape; in the dorsal region, from the middle downward, the left anterior columns were smaller, atrophied, and full of corpora amylacea, finely fibrillated; the anterior horn cells were smaller than those of the opposite, in part completely disappeared. In the cervical and lumbar regions the multipolar ganglion cells were smaller and darker than normal, and destitute of broad processes, but not to be compared with the atrophy seen in progressive muscular atrophy. In the lower part of the cervical portion there was a small microscopical patch of sclerosis.

The Administration of Morphia Hypodermically in Large Doses.

In the *Practitioner*, June, 1880, Mr. Park reports several cases illustrative of the advantages of using morphia very freely. In Case 1, a strong, healthy woman, aged thirty-six, who was admitted with delirium tremens, he gradually injected three grains before producing any effect. After a good sound sleep she awoke well. Two days subsequently she became again noisy and restless; he therefore injected two grains without producing the slightest effect. For two days she continued unmanageable, when five grains of acetate of morphia were injected deeply, under the subcutaneous fat; half an hour afterwards she dropped asleep, and slept till morning. In another case, a man suffering from sciatica, three-and-a-half grains were necessary before relief could be obtained. Sleep was never produced as a direct result of the injection, so far as could be noted. Occasionally, large doses appeared to act as purgatives; certainly it cannot be averred that the constipation was increased either by large or small doses. In a case of granular Bright's disease, where large doses were frequently given, and, at times, continuously, for the relief of insomnia and orthopnœa, not only was the palliation greater than expected, but the patient's life was greatly prolonged. Several other cases are quoted at some length, showing how beneficial large doses often proved. Mr. Park's conclusion is that the sedative, anodyne, and hypnotic effect of morphia do not go together. Hypodermically administered, and even in large and toxic doses, the hypnotic result may not be obtained. In certain cases of mania, the tolerance is very great. In practice it often happens that three minutes to half an hour elapse before the full effect of an injection becomes manifest, and often minutes elapse before the patient himself is conscious of any effect. It is remarkable that in no one of the cases in which Mr. Park used the very large doses recorded did any of the ordinary phenomena of narcosis ensue—a very different result to that which would necessarily follow administration of like doses by the mouth or rectum.

Physiological Test of Intoxicants.

Dr. Shorthouse says, so the *British Medical Journal* informs us, that if a man partake of too large a quantity of good sound wine, or malt liquor, he usually staggers about from side to side, his gait is very unsteady, and if he come to grief and to Mother Earth, he generally falls on one side or the other. If he take too much whisky, especially that abomination which goes by the name of Irish whisky, he is almost certain to be seized with an irresistible impulse to fall forward on his face. If he get drunk on cider or perry, the latter more especially, he is certain to fall down suddenly on his back, and apparently without any previous warning. He once saw a number of men who had made too merry at a harvest feast all fall down on their backs, get up again, and fall down again in the same manner. He had never witnessed anything of the like kind before; and was not a little amazed as well as amused. The farmer, who was a very shrewd Herefordshire man, told him that that was the effect invariably produced by perry, of which his men had that day partaken liberally. He has since that time seen several isolated cases, which have corroborated the farmer's version of the action of an overdose of perry or cider. Habitual drinkers of cider or perry are more liable than other persons to paralysis of the limbs; probably this may be due to the sugar of lead with which some cider-makers "perfect" their beverage. It would appear then, according to this very curious but very doubtful observation, that the various drinks act on different parts of the cerebro-spinal system which preside over locomotion, or act upon the various parts in a different manner, or why these varieties in the method of falling?

The Regulation of Body Heat.

A Fränkel, in *Centralblatt für die Med. Wissenschaften*, endeavors to solve the question, in what way and through what means, during changes in the production of heat in the body, the changes in the cutaneous circulation which make up the compensation through the giving off of heat, are effected. Heidenhain—as is well known—was the first to prove that the heat of the body is affected by the system of nerves under the sole agency of the circulation, by showing that, under reflex as well as indirect irritation of the medulla oblongata, the temperature of the blood in the large vessels decreases. The acceleration of the blood stream, observed by Heidenhain, has been traced by Ostroumoff to an irritation of the nerve-fibres which dilate the vessels. Over-production of heat in the organism under normal conditions, is dependent upon strong muscular activity and increased food absorption, both of which go hand in hand with increase of production of carbonic acid. The carbonic acid, however, directly irritates the centres located in the medulla oblongata, and consequently the formation of this end-product of the change of matter must be also connected with regulation of heat. As the accumulation of carbonic acid coincides with deficiency of oxygen, the author tried to decide his task by insufflation of differently combined quantities of carbonic acid, oxyven and nitrogen into the lungs of dogs. The insufflation was done with a compressible India-rubber ball, which was connected by a three-branched tube cannula, tied into the trachea of the animal, with gas-reservoirs, and with the atmospheric air. The cutaneous temperament of the paws and that of the rectum were measured. Some days before carrying out these experiments one sciatic nerve was cut through, in order to ascertain, by comparative measurements of both hind-paws, whether the changes in the cutaneous temperature, eventually to be observed under the influence of insufflation, originated from a changed innervation of the vessels remaining in connection with the centres or not. Three series of experiments showed, on the side on which the sciatic nerve was uncut, a rise of temperature; on the paralyzed side a standstill, or even fall of temperature. The inconstancy of the influence of the accumulation of carbonic acid on the irritation of the nerves dilating the vessels, observed by the author in other experiments, he traces back to prolonged restraint of the animals, and the simultaneous decrease of the temperature inside the body, and the continuous influence of the curare. The author is now of opinion that the increased production of carbonic acid in the organism, which occurs in increased temperatures under the influence of muscular activity, as well as of absorption—absorption of food—is one of the factors which regulates the activity of the nervous apparatus that governs the extent of the production of heat.

Hygienic Screens.

Mr. Wentworth Scott, says the *British Medical Journal*, recommends the employment of slag wool or silicate cotton, as a convenient disinfectant or odorizing medium. By impregnating the silicate with carbolic acid, thymol, or iodine for instance, and passing a current of air through the mass, which for such purpose is conveniently

contained in a box or case, the opposite sides of which are perforated, the air then will be incapable of communicating disease-germs, however foul it may previously have been. If eucalyptus oil, or other odorous substance be substituted for the preceding, the wool will impart an agreeable fragrance to the air-currents passing through it. The silicate may be renewed at any time, even if clogged with much dust and organic matter, by simply baking in a hot oven for a short time, and can then, of course, be charged again. Mr. Scott proposes to use these hygienic silicate screens in connection with the doors and windows of hospitals, schools, public buildings, and private dwellings. A form of safety respirator, for the use of nurses and others, on the same principle, is also suggested.

The Treatment of Diphtheria by Carbolized Camphor.

M. Peraté has, according to *Bulletin de Thérapeutique*, July 15, 1880, for the last two years used carbolized camphor for the treatment of diphtheria. He paints the surface with a pencil dipped in the following mixture: Carbolic acid, 9 grams; camphor, 25 grams; alcohol, 1 gram, diluted with equal parts of the oil of sweet almonds. The paintings are made every two hours in the day, and every three hours in the evening; then, after some days, they are divided by periods of three, four, or five hours, according to the improvement of the patient. These paintings are made over the whole extent of the false membranes, and with troublesome children the pencil is plunged as deeply as possible to the bottom of the throat, being of course, previously drained. The mixture has an extremely disagreeable taste, to which, however, the patient soon becomes accustomed. M. Peraté has been very successful with this plan of treatment.

The Treatment of Perspiration of the Feet.

Dr. Ortega, in *Le Praticien*, advocates the use of a solution of chloral in this affection. A patient of his, a strong man working in an ice manufactory, suffered from it in an extreme degree, so much so that his fellow workmen would not work by his side. The epidermis of the soles of the feet was white, as if macerated: there were small ulcerations in the furrows, and also around the nails. The odor was overpowering. Dr. Ortega prescribed baths of a solution of chloral, one in fifty, and wrapping the feet in a cloth dipped in a similar solution. Two days after the smell had disappeared. Six days later, the treatment being continued, the ulcerations were less moist and covered with a layer of epidermis.

Correspondence.

Professional Ethics.

Ed. Med. and Surg. Reporter.

An editorial article in a former number of your valuable journal pictured in appropriate manner the position of the city physician in pursuit of professional business at the various places of summer resort. The means adopted by the wandering Æsculapius to secure for himself the visitor who shall help him to pay his bills as he sojourns in the midst of pleasure and practice, and the position of the unfortunate country physician subjected to the lowering estimate of the *Eminent* from abroad, were no imaginary pictures. As corroborative of your statement, allow me to relate the following incident, which occurred a few days since, and "points a moral," as well as "adorns a tale." A gentleman at one of the hotels had been *unfortunate!* enough to fall into the hands of a resident practitioner, and was being waited upon by one of the hall boys of the house.

"Who is your physician sah?" queries the boy.

"Dr.—— one of the resident physicians," replied the gentleman.

"Is he one of de *lower order* of physicians in de village? I knows a good physician sah, stopping at the Grand Union, from New York sah."

"Yes?" replies the gentleman. "Who is he? "Dr.——," naming a New Yorker, in regular attendance upon our summer season, in pursuit of professional business.

The gentleman *expressed* his satisfaction with his present attendant, and the representative of the physician of a *higher order*, retired. "*Verbum sat.*" E. X. P.

Saratoga, July 31st, 1880.

The Quinine Mania.

Ed. Med. and Surg. Reporter.

Forty years ago the sulphate of quinine was used as an antiperiodic, in diseases assuming the periodic form, and, occasionally, as a tonic in other diseases; now it is a general panacea; for where is the disease in which it is not used? Young and old, weak and strong, get their quinine. If the infant a few weeks old sneezes, the mother or nurse cries out, "the baby is getting cold and must have some quinine;" and quinine it gets, as regularly as its nourishment. The elegant lady, who, in consequence of her indolent habits or the exposures attendant on fashionable life, does not feel quite well, reclines on her lounge, or lolls in her easy chair, and calls for her "keeneen."

After describing the diseases in which quinine is useful, Dr. Geo. B. Wood wrote, "but in all these cases it greatly behooves the physician to examine well the condition of the system, and

before resorting to the tonic (quinine), to ascertain the real existence of an enfeebled condition of the functions, and the absence of such local irritations or inflammations, especially of the stomach or bowels, as would be likely to be aggravated by its use."

Who stops to do this now? If a patient's temperature is too high, or too low, quinine brings it to the normal standard all the same. Irritable brains or stomachs must take care of themselves, for quinine is infallible.

The tyro, need not trouble himself about the therapeutics of quinine. If we accept the practice of the present day, it is omnipotent for good and at the same time harmless.

Who can say that the brain troubles of typhoid fever are not exaggerated by the excessive use of this remedy in that disease?

Is there no risk in giving it to the infant, whose brain is already predisposed to diseased action by teething, etc.?

This general use of quinine is a fine thing for the manufacturer, but for the physical and financial benefit of the community, let us stop the unnecessary use of this drug.

[illegible] W. [illegible], M.D.
[illegible], N. J.

News and Miscellany.

Famine in Asia Minor.

Recent news from the famine-stricken districts in Asia Minor, says the *Lancet*, August 21st, 1880, give a deplorable account of the state of the populations in the districts between Erzeroum and Bayazid, and in the districts of Van and of Mossul and the intermediate tract of country. The scarcity of food in these localities is extreme, and in many places the people have been trying to support life on wild herbs. The deficiency and high price of grain has, moreover, led to not more than a fourth of the usual amount being sown. The destruction among the flocks in the affected districts, partly from the severity of last winter and partly from the want of forage, has been enormous. It is estimated that half the oxen and three-fourths of the sheep have perished. Deaths from starvation have been very numerous, and the evidences of chronic starvation among the survivors are shockingly apparent. Typhoid, typhus, dysentery, scurvy, cerebro-spinal, meningitis, and small-pox are mentioned as the most prevalent diseases in these districts, and fears are entertained of some localities that, unless the Ottoman Government interfere with relief, worse evils from want than have yet been experienced are still in store.

Antivivisectionists.

The memorial recently presented to Mr. Gladstone, urging him to do all in his power for the absolute abolition of vivisection, was signed by "one hundred representative men," among them Cardinal Manning, Prince Lucien Bonaparte, Alfred Tennyson, Robert Browning, James Anthony Froude, John Ruskin, the head-masters of Rugby, Harrow, and seven other large schools; twenty-one physicians and surgeons, and thirty-seven peers, bishops and members of Parliament. The memorialists take the ground that vivisection, even with anæsthetics, should by law no longer be allowed, and they quote the opinions of Sir William Fergusson, Sir Charles Bell, and Dr. Syme, that "it has been of no use at all and has led to error as often as truth." They add, that the utility, if proved, would not, in this case, excuse the immorality of the practice.

Dr. Leffingwell's paper, "Does Vivisection Pay?" which recently appeared in *Scribner's Monthly*, excited much discussion in London papers. It is said that Dr. Wood's reply, in the September *Scribner*, presents the other side with equal force.

Professor Gross.

The safe return of Professor Gross from his trip across the ocean will be welcome intelligence to all our readers. While in attendance upon the meeting of the British Medical Association the worthy Professor was the recipient of a high honor from the University of Cambridge. On August 11th, at 12.30 P.M., Prof. Gross, in company with several other distinguished members of the medical profession, had conferred upon him the degree of Doctor of Laws. It will be remembered that upon a former occasion he had received the title of Doctor of Civil Law, from Oxford. May he long live to enjoy his well merited honors.

OBITUARY NOTICE.

Philip De Young, M.D., one of the oldest practicing physicians in Philadelphia, died suddenly at his residence, 242 North Fifth street, recently. Dr. De Young was born in Montgomery county, in 1809, and studied medicine in this city, graduating from the University of Pennsylvania in 1838. He was immediately appointed physician of the Lehigh Navigation Company, through the influence of the late Asa Packer. Desirous of a wider field of action, Dr. De Young came to Philadelphia, in 1844, and has since been in active practice here. He performed a surgical operation on the day preceding his death.

QUERIES AND REPLIES.

Dr. Geo. P. Oliver writes:—

Dr. E. M. M., of New York State, will find the following an excellent remedy for "itching of the scalp and falling off of the hair:"—

℞.			
	Hyd. chlorid. mit.,	℈j	
	Glycerinæ,	f℥j	
	Cerat. plumbi subacetat.,	℥ij	
	Ung. aquæ rosæ,	℥j.	M

Apply morning and night.

A Subscriber wishes to know if there is any way of entirely eradicating the Pin-worm (ascaris vermicularis), in a man fifty-seven years of age, who has been troubled with worms for seven years, and tried all the usual remedies without any benefit.

DEATH.

THOMASON.—At his late residence, Perrineville, N. J., on Friday morning, Aug. 20th, Thomas J. Thomason, M.D., aged 47 years.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1229] PHILADELPHIA, SEPTEMBER 18, 1880. [Vol. XLIII.—No. 12.

Original Department.

Communications.

INFLAMMATIONS OF THE URETHRAL MEMBRANE, FROM A SURGICAL STANDPOINT.

BY GEORGE HALSTED BOYLAND, A.M., M.D., ETC.

Synonyms: Blennorrhœa, Gonorrhœa, Urethritis, Gleet, Stricture.

Cornelius Celsus, who lived in the first century after Christ, and wrote at Rome his "De Medicina," already recognized the fact that there were certain diseases in which manipulation played the principal rôle, and devoted what at that period was doubtless considered a vast amount of literature to the subject of surgery, namely, one volume out of the eight that comprise this work. His definition of surgery is: "ea non quidem medicamenta atque victus rationem omittat; sed manu tamen plurimum praestat: estque ejus effectus inter omnes medicinæ partes evidentissimus." From that date surgical cases began to be considered by themselves, and the distinction, gaining force and weight by years, has been transmitted to the present generation in the form of a grand and separate department of science, with whole libraries of volumes on the subject of surgery alone, with schools devoted exclusively to its study, and with perhaps thousands of well trained men who practice that branch only. And yet it is impossible to draw the line (although the existing importance justly claimed for their art is urged by the surgeons as a reason for drawing it) between the fields of surgery and medicine. There is between them a wide border-land or neutral zone, which belongs to neither and is nevertheless common to both, embracing not a few diseases appropriated now by medical writers to their manuals and standard works, then by surgical writers to theirs. Again they appear in both. It is from this border-land that the obstetricians, but more especially the gynæcologists, have reaped such a harvest, and it is upon it that the latter have entirely built what may not inappropriately be called their craft. No class of diseases better illustrate this point than inflammations of the mucous membrane of the urethra; and no medical or surgical work of practical import is without a chapter on them. The question, do such inflammations belong to the domain of surgery? is certainly answered in the affirmative by the etymology of the word "surgery" itself, viz: *cheir* and *ergon*. So much for technicality. Therapeutically, surgery does the most, although medicine becomes at times a necessary adjuvant; but for the simple reason that it is so, there would be no more propriety in placing inflammations of the urethra in the department of inner medicine, than there would be in claiming certain cases of pleurisy for surgery because it is deemed advisable to blister, paint the chest with iodine, or use Dieulafoy's aspirator. Assuming, then, for these reasons, that such inflammations and their treatment belong, strictly speaking, to surgery, they will be considered from a surgical standpoint.

The symptoms and course of these diseases are sufficiently familiar to be omitted from this paper, which will be limited to a brief summary of their ætiology, pathological anatomy and treatment.

Inflammations of the urethral membrane are of two kinds only, acute and chronic. In the

first category belong all acute discharges, whether traceable to a coitus, to another irritation of the membrane, or to a wound. As blennorhœa is much more frequent in man than in woman, inflammations of the male urethra only will claim attention here.

Ætiology.—A causal factor in the production of blennorhœa, usually overlooked in the books, is sexual intercourse during menstruation, both parties being in perfect health. It is not intended to say by this that sexual intercourse under these circumstances is invariably, or even usually, a direct cause; for it is well known that such practice has been done without other results than filth, moral degradation, and a passing but slightly painful hyperæmia. Nevertheless, one of the most painful and obstinate cases of urethral blennorhœa that the writer was ever called upon to treat came directly from this source. The walls of the vagina being richly furnished with mucous cells, the irritating influence of the menstrual flow sets them in motion and readily transfers them to a membrane of exactly the same character, that of the urethra. Arrived there, they set others in motiou; these in their turn do likewise; and so on until the discharge appears; the surrounding inflammation in which the corpora cavernosa participate causing a stasis or engorgement of the veins, which do their part in facilitating by pressure the transudation of white blood corpuscles, which help to make up the discharge. Predisposition to such inflammations would naturally exist with over development of the membrum virile, with large and protruding lips of the meatus urinarius externus. The extra amount of blood required in this case, together with the larger supply of sensible, motor and vaso-motor nerves, together with the greater vascularity, must necessarily have their effect upon the central nerve system, which in its turn acts with reflex irritability upon the unnaturally large sexual organ. Hypospadias and epispadias, when not existing to such an extent as to prevent coition altogether, are to be placed in the class of predisposing causes. These malformations readily allow the vaginal secretions to enter directly into the middle of the urethra. Lymphatic temperaments, generally blondes, are more susceptible than others, and being infected are less speedily cured.

Moist climates have been considered more favorable to the development of gonorrhœa than dry ones, but my experience has been just the reverse. It is related of Ricord, that he invented a menu of such a character that one partaking of it, and having normal sexual intercourse thereafter would become affected with blennorrhœal urethritis. No proof is given that this experiment was ever actually made; but certain articles of food unquestionably find a place here; in fact, all articles of food and drink of an irritating or exciting nature, as, for example, spices, truffles, asparagus, shell fish of all kinds, coffee and spirits are, but very doubtfully, considered as predisposing.

Whether these articles of food and drink take an active part in bringing about blennorrhœa or not, the fact remains the same, that if partaken of during the actual course of the disease, they undoubtedly aggravate the symptoms and will cause a reappearance where it is apparently healed. Drunkenness especially favors the infection. As causes of urethral blennorrhœa, are to be cited rheumatism, scrofula, gout, and tetter, also without sure ground. These diseases, in the opinion of the writer, ought to be classed as possible suites or complications of gonorrhœa, rather than as causes; where they exist with gonorrhœa they are not without considerable influence upon its severity and length of course. It will be observed, in persons suffering with rheumatism, that blennorrhœa runs out and dries up quickly when a rheumatic attack comes on but returns as quickly when the affection of the joints diminishes. Other causes of a more direct nature may consist of physical or chemical applications, as, for example, calculi, oft repeated use of the catheter, injections of caustic ammonia and nitrate of silver. Most frequent of all, gonorrhœa results directly from sexual relations, which on their side again can act in many different ways. Here belong too oft repeated coition, notably with unproportionate largeness of the penis or narrowness of the vagina; further, masturbation, contact with the lochia, with discharge from cancer, in carcinoma of the portio vaginalis. This, however, is extremely rare; for married men, who by the sexual act touch the mouth of the uterus with the most vascular portion of the organism, do not contract disease from that source as a general rule. Leucorrhœa is also, though without certainty, ascribed as a cause.

By far the most important ætiological factor in diseases of the urethral membrane is the immediate influence of the muco-pus or pure pus secretion of a vaginal or uterine catarrh or gonorrhœa of these organs.

Pathological Anatomy.—It would perhaps have been more àpropos to say that the subject of pathological anatomy would not be considered, or at most only glanced at, in

this article, as it is quite scant as regards blennorrhœa, for the simple reason that only when patients suffering from it die, by chance, of some other disease, is opportunity given for morbid anatomical investigation. There is present redness, swelling, thickening of the mucous membrane, follicular ulcers, infiltration of the submucous tissue with plastic exudation, abscesses in the same, and when these point and break inwardly, also ulcers, which heal with considerable contraction of the urethra, caused by the scar which they leave, and which not unfrequently becomes later the seat of stricture.

The seat of acute inflammations of the urethra is considered by many to be close behind the fossa navicularis. Doubtless this is the case when a patient is attacked for the first time, supposing the cause to be vaginal secretion. But personal observation on a patient suffering from two cases of gonorrhœa, with an interval of health between them, made it perfectly clear that the seat of the second attack was the pars membranacea, there being absence of pain at the fossa navicularis and no chorda, both of which were present during the first attack. But contrary to the generally accepted opinion that each succeeding case in the same patient is milder and less painful, the second attack in this instance was, if anything, more severe and more extended than the first.

The absence of chorda in this and other second attacks, both being acute, is further evidence that the pars membranacea was the part affected; although the intensity of the inflammation is generally greater in some places than in others, and thus forms insulated spots, yet from the very nature of the membrane must the inflam mation extend over its entire length. In aggravated cases the inflammation spreads on to the fibrous wall of the urethra, and from thence to the corpora spongiosa and corpora cavernosa, and causes, by production of new connective tissue, knotty and hard patches, which hinder the flow of blood to that part of the corpora cavernosa, and this, coupled with the extreme irritability of the nervi errigentes, causes the frequent and painful erections designated as chorda. This condition varies as to severity. In one very acute case the writer afterward remarked sidewise chorda, evidently from the fact that *one* corpus cavernosum was affected. Views differ much as to the morbid nature of the gonorrhœal effusion; even at this late date, who can state positively and in general that the same does not go hand in hand with true syphilis, when undoubted authorities and excellent observers have placed upon record cases in which secondary syphilitic symptoms followed upon an ordinary gonorrhœa in just the same manner in which they follow upon an indurated chancre. Such an occurrence, however, seems to be rather an exception.

The great majority of urethral blenorrhœas, even when contracted from infectious discharges, be these discharges from soft chancre or from gonorrhœa, have only local significance, apart from gonorrhœal rheumatism, and such other diseases as owe their existence to a spread of the inflammation in the continuity of the mucous membrane, or in the lymphatic system. In the first category belong epididymitis, prostatitis, cystitis and even nephritis; in the second, inflammatory, painful buboes.

Space will not permit a discussion of the question whether gonorrhœal inflammation of the urethral membrane are identical with lues or not; therefore, after a word on chronic urethral inflammations the subject of treatment will be dealt with. The etiology of chronic inflammations of the urethral membrane may, in most cases (when no constitutional disturbance from other sources is present), be covered by the remark that such inflammations are due solely to neglect on the part of the patient, or to bad practice during the acute stage, on the part of the medical attendant, usually the former. The post-mortem appearances of the membrane in chronic inflammation of the urethra, or gleet, differ but little from those of the acute stage, except when an old stricture is found. Otherwise, there are the same insular spots, but of a more livid character. Thickness of the mucous membrane and submucous tissue are present, and as a natural consequence of the thickening there is narrowness of the urethral lumen; such narrowness may exist in several forms. In some cases the urethra is narrowed to the extent of several Paris lines only, its walls being thick and callous, but smooth or in form of a knotty prominence or of a long, uneven fold. At times the stricture shows a round sort of pad, which, like a ring, encircles the entire lumen of the canal, or is limited only to a portion of its periphery; at others it takes the appearance of a sharp, well-marked string. Again is seen an irregular protuberance which draws the mucous membrane in a wrinkle to it. The most frequent seat of stricture is in the vicinity of the bulbus urethræ, a natural consequence of what has already been mentioned, but is not generally accepted that, although the first gonorrhœal affection may have its seat close behind the fossa navicularis, each succeeding one

goes higher up, until finally a stricture is developed, sometimes almost at the entrance to the bladder. An exceedingly rare post-mortem appearance is induration of a pituitary gland, that can also narrow the lumen of the urethra. Chronic inflammations of the urethra, strictly speaking, possess no other property than the chronic blenorrhagic process of other mucous membranes; it matters not whether they be classed in the same pathological species as simple inflammations of the urethra, or whether they be designated as urethritis of a different type, contagious and virulent. Although this process, on account of either severity or position, may present different forms, they are rather different degrees of the same form. There is, therefore, no reason to push theory to the extent that is practiced by our foreign confrères, nor to embark with them upon a sea of technicalities, in endeavoring to distinguish and describe chronic inflammations of the urethra as simple, croupous, papillary, granular and follicular. There are only two inflammations of the urethra, an acute and a chronic; consequently, only one chronic inflammation, which runs its course at times with, at others without, tumefaction of the membrane; at times with, at others without, accompanying affection of the glands, passages and saccated formations that belong to the urethra. The so-called granular inflammation is in itself no more a special pathological anatomical definition of chronic virulent inflammation of the urethra than the granulation of any wound in general surgery would be of it. It was doubtless the spotted or granular appearance of certain patches in post-mortem urethræ that gave rise to the name. When granulation takes place in a wound there is an effusion, which is designated pus, but which varies, as to chemical composition, according to the physical nature of the wound. It is much the same with all inflammations of the urethra; and it being to the interest of science to simplify as much as possible the introduction of such distinctions as those mentioned above, the bringing into our already replete nomenclature such terms as "rirus granuleux," are not only confusing and unscientific, but absurd. The term granular inflammation has been selected as being the most prominent and at the same time the most plausible in the list of misnomers; as being, moreover, that in which others distinguish different varieties, consisting now of a papillary growth of the mucous membrane or of an early stage of wart-like excrescence, then of a follicular process of growth or of a trachoma. The trachoma of the conjunctiva exhibits real granulation, which chronic inflammation of the urethra does not. Inflammations of this character change readily to hypertrophy. There appears in the membrane a spongy mass, easily pushed aside, which later becomes a cicatrix and contracts into a string of tissue. Every stricture of the urethra from a gonorrhœal scar is the final stage of chronic inflammation, and the direct outcome of such a soft hypertrophic process of the mucous membrane. A pathological relation between this and the individual granum cannot be shown, and has never been found on any specimen that ever came under the observation of your author. But every process of chronic inflammatory infiltration and hypertrophy followed by shrinkage, whether ulcers are present or not, without gonorrhœa having gone before, is subject to the same pathological anatomical laws, be the chronic inflammation suite of an acute form or be it chronic *per se* from the very beginning.

Treatment.—The examination of the urethra must, in the general run of cases that come under observation, be limited to the sense of sight and touch, as in the beginning of an acute inflammation of the membrane every instrumental procedure is to be studiously avoided. As to practical purposes and ends, the examination internally of the urethral membrane, even when the inflammation is not severe, and the discharge has lasted already several days, is not really necessary. The use of instruments, which at a certain stage of the disease undoubtedly does become necessary, should, as a rule, be put off until the latest possible moment. Even in the chronic stage of an ordinary gonorrhœa—which in many cases follows the acute stage typically, and generally ends in healing after a course of several weeks' duration—experience proves that it is not necessary or indeed advisable to introduce instruments. After the regular chronic stage, the blennorrhœa assumes an entirely different form, and appears about to enter into a second chronic stage of a subcutaneous or submucous character. The practitioner has no difficulty in recognizing this point in the course of the disease, the point at which the question of instrumental interference is to be dealt with. The internal examination of the urethra is effected by means of sounds, bougies and the endoscope.

In sounding, the object in view will be best attained not so much in an examination by *introduction* of the sound, as in certain diseases of the bladder, but by introducing it, which should

be done very slowly and with the utmost care. Of course, if there were an old stricture the *introduction* would furnish valuable information as to size, toughness, etc.; but we are dealing with the membranes now at the outset of gleet, before the formation of stricture considered solely as stricture, and which would indicate the regular mechanical treatment. As the instrument is withdrawn, then, strict attention should be given in order to detect any wincing, grimace, or exclamation of pain, smarting, or even inconvenience, on the part of the patient. The sound will at once furnish the requisite information as to there being or not being a resistance offered at any point along the urethra. To ascertain this the more perfectly a sound with a small elongated button on the end should be used; one of malleable silver, and No. 5, will be found to suit most cases best. The pliability is a strong point, as the regular sounds sold in the shops are all more or less on one pattern. and curve accordingly. In case of any slight malformation about the neck of the bladder, or small prostatic enlargement, or difference in the arc described by the pars membranacea just before it terminates at the vesical entrance, the danger of ripping, tearing, or making a false passage, readily incurred by those not well practiced in the use of instruments, would be avoided. The pliable instrument being introduced and found upon *very gentle* manipulation not to proceed further, should be withdrawn, bent so that its convex edge or back will form a different arc, and again introduced. If it does not now glide readily in, the process should be repeated a second time, and so on until a soft and easy entrance is effected. In withdrawing it will be ascertained: 1st, Whether there is a hindrance distinct and of itself. 2d, Whether there is a place of especial tenderness and sensibility. 3d, Whether a slight bleeding occur. If it is fixed, from this instrumental exploration, that there is no resistance, and hence no narrowing, but that there is hyperæsthesia of the membrane, a further examination by means of the endoscope may prove useful. This instrument is not a new one, but was introduced by Desmoreaux, as long ago as 1853; it has since been improved upon and used quite generally. It is merely an application of the principles employed in the construction of the vaginal, the rectal, the nasal, the aural, and other specula, and the laryngoscope. It has, in fact, been lately carried to such perfection as to present, by means of a strong light thrown through it, a satisfactory view of the posterior wall of the bladder. The endoscope, or more properly the *urethral speculum*, consists of two blades, which screw apart, and are highly polished on the inside, the better to reflect the powerful light thrown in when they are opened. By moving it forward, backward, or around, as need be, a view of every portion of the urethra can be obtained. The membrane, on account of its elasticity, will be stretched taut during the use of the endoscope, and thus danger of a fold being caught between the branches will be avoided. The urethra is capable of considerable distention, and can only be thus explored when the lumen of the instrument is in a direct line with that of the urethral canal; and the movements from side to side must, when made, always be in the central field of vision. It will thus be seen that the lumen of the urethra, from the orificium externum to the bulbus, is perfectly central, except in the membranous portion, where it will appear excentral generally, pushed up, as it were. This view of the human urethra must be our guide in all pathological comparisons. The appearance of the membrane is, of course, different at different points of its extent, as is frequently observed, and as the discharges would already indicate. Injections of strong irritating or caustic solutions, as for example, nitrate of silver, or chloride of zinc, sometimes employed as abortive measures in the treatment of gonorrhœa, are not advisable, because a much larger surface is burned (the diseased one only being presumably our objective point), and the inflammatory process is thus spread, a circumstance not unfraught with danger. The writer only tried the abortive treatment in one case, years ago. It caused intense pain, followed by bleeding, which soon ceased, then the gonorrhœa came back and ran its usual course. The local employment of an irritating caustic by pencil, lapis infernalis, as suggested by Auspritz, is preferable to a solution if the abortive treatment is insisted on, care being taken to pass the pencil in behind the fossa navicularis. Injections with the syringe seldom reach beyond the symphysis. If it is desirable to bring the solution in contact with that part of the membrane behind the bulbus, the injection should be given by the physician. A gum catheter with eye at the end made a little larger than the ordinary eye, will aid materially, if the injection be made through it. Weak, non-irritating injections have the same effect upon the catarrhal mucous membrane that watery antiseptic wound dressings have upon the surfaces to which they are applied, viz: cleansing, refreshing, and relieving. Such injections ought to be used from the very beginning. The patient should be shown how to use the syringe, to elevate the penis with the

left hand during the injection, which is done with the right hand, grasp the meatus urinarius externus between the thumb and fore-finger of the left hand as the syringe is withdrawn, and to hold the fluid for ten minutes inside. Solutions of plumb. acet., or bismuth and morphia, are best, and by following this plan particles of them cling to the mucous membrane and continue the therapeutic effect after the injection is emptied. A better method of introducing these drugs is to have long pellets made, thin enough to slip easily into the urethra, and left there to dissolve, which they will do in twenty or thirty minutes, if made up with oleum theobrom. Salves, pastes, and irritating compositions only do good when left for a long time in contact with the membrane; they are not convenient, or to be relied on. The resinous preparations, copaiva, tolu, matico, tar, turpentine, etc., have produced digestive trouble and given no benefit, in my hands. It is scarcely necessary to state that very much depends upon the diet, which should be as simple and as meagre as possible. The only drink besides weak tea and coffee should be water, in which a handful of linseed has been thrown and allowed to settle at the bottom, before using. The soothing effect of copious draughts of this liquid on the mucous membrane is very great. The bowels must be opened regularly, frequent baths taken, and a suspensory worn. In this way an ordinary gonorrhœa will not last more than from four to eight weeks. The advent of another disease not syphilitic will cause an immediate and permanent cure; this is especially the case with cholerine.

ON AFFECTIONS OF THE EYE CONSEQUENT UPON WHOOPING-COUGH.

BY DR. M. LANDESBERG,

Of Philadelphia.

The statement of Sir C. Bell, that the contraction of the lids during every violent act of expiration supports the eyeball and its blood vessels, and guards them against the violent rush of blood which attends every great expiratory pressure, has been fully corroborated by the later investigations of Professor Donders, of Utrecht, made by suggestion of Ch. Darwin. During every violent expiration the blood vessels of the eye are greatly distended, the pressure of the blood in the arteries being increased, and the venous circulation retarded. Under these circumstances ruptures of vessels of the eye would be of very frequent occurrence, if the firm closure of the eyelids and their pressure against the eyeball should not limit or totally remove the dilatation of the vessels.

But even this support given to the vascular system of the eye is not always sufficient in order to prevent ruptures of blood vessels during violent expiration. In many instances of violent coughing, vomiting or sneezing, we not unfrequently meet with numerous ecchymoses of the lids, and the conjunctiva of the eyeball, caused by ruptures of small vessels, which, notwithstanding the closure of the lids, could not resist the force of the expiratory effort. Such extravasations, however, are in the majority of cases inoffensive, and resorption may take place spontaneously. But there are instances in which the rupture of blood vessels consequent upon violent expiration gives rise to serious morbid alterations of the eye, which may seriously endanger its function.

Of the latter category four cases came under my cognizance during my practice, the report of which will be of some interest to the profession.

Case 1.—V. A., seven years old, brought to me July 16th, 1872, is suffering from whooping-cough, the attacks of which are very violent during the night. On the morning of July 13th, after a night of violent coughing, the eyeballs and the lids were suffused with blood, and vision of the right eye was almost totally obscured.

Examination showed numerous hemorrhagic extravasations scattered on the eyeball and the lids of both eyes.

Right Eye. Media clear, pupil somewhat dilated, reacts but very slowly on reflex action. Tissue of iris, intraocular pressure normal. Of vision only quantitative perception of light. Optic disc of reddish hue, somewhat swelled and of indistinct outlines. The whole surface of retina infiltrated. Macula lutea appears like a red disc, with a cherry-red spot in its centre. Arteries are very thin, veins engorged and tortuous. The circulation of blood is interrupted in one upper arterial branch.

Left Eye. Normal. $V = \frac{1}{1}\frac{5}{5}$.

Apparatus of circulation and respiration normal.

I resorted to daily hypodermic injections of two milligrams of strychnia into the right temple.

July 17th. $V = \frac{15}{100}$. Jæg. 15. Pupil of normal shape, reacts slowly consensually, somewhat better on reflex action. Optic disc less swollen; peripapillary region more distinct. Arteries more filled up. Macula lutea of paler hue.

July 19th. V = $\frac{15}{70}$. Jæg. 10. Reaction of pupil normal. Optic disc only slightly pushed forward, of more distinct limits. Serous infiltration of retina very slight. Veins less distended and tortuous. Arteries more filled up. The central spot of the macula lutea is of brownish color. The blood current is interrupted in two upper arterial branches.

July 23d. V = $\frac{15}{40}$. Jæg. 3. Optic disc somewhat opaque in its inner half, palish in the outer one. Arteries somewhat thinner than on the left eye. Veins are normal. The obliteration of the two upper arterial branches is progressing. Retina and macula lutea are normal.

July 26th. V = $\frac{15}{30}$. Jæg. 2. Optic disc of palish hue. The two obliterated upper arterial branches are marked as fine white bands upon the red ground.

The treatment is discontinued, when two further injections of strychnia did not alter the last result.

Case 2.—A workman's child, three years old, suffering from whooping-cough, was under my treatment, from the first day of May, 1879, for phlyctenular keratitis of the left eye. The right eye was normal. Paroxysms of whooping-cough often occurred, consequent upon the violent struggling and crying of the child during medical attendance. May 14th. After the eye had been attended, and while the mother was trying in the waiting room to quiet the screaming child, a very violent fit of whooping-cough broke out, and immediately afterward the mother rushed into the office speechless with consternation. I ascertained, at once, *a complete exophthalmus of the right eyeball.* The latter was immovable, and protruded from the orbit in the direction of the optic axis. The conjunctiva of the eyeball was slightly infiltrated, intensely injected and sprinkled with numerous large and small hemorrhagic extravasations. The cellular tissue of the orbit and the lids were suffused with blood, and the lids pressed against the æquator bulbi, leaving about half of the globe uncovered. Media were normal. Pupil was somewhat contracted. On dilating the latter, ophthalmoscopic examination showed hyperæmia of the optic disc and the retina. Arteries normal. Veins dark-red, largely distended and tortuous. The condition of vision could not be ascertained.

Abstaining from all therapeutics, I applied a protective bandage only. Resorption of the blood took place spontaneously. There was complete restitution ad integrum.

Case 3.—W., farmer's son, seven years old, was brought to me January 15th, 1880, on account of impairment of vision, which had set in three days before, consequent upon a violent fit of whooping-cough.

Examination showed numerous hemorrhagic extravasations over the conjunctiva bulbi, the lids and the adjacent parts of both eyes.

Right Eye. V (somewhat eccentric) = $\frac{15}{50}$. Jæg. 6. Central scotoma. Visual field contracted in the medial upper quadrant. Media clear. Reaction of pupil normal. Optic disc somewhat hyperæmic, covered with small ecchymotic spots. Margin of optic nerve somewhat hazy, occupied in its nasal part by a large hemorrhagic extravasation; large ecchymoses are scattered on the nasal half of the retina. Veins are somewhat distended, arteries normal.

Left Eye. Normal. General health good. Treatment was not agreed to at the time.

When I saw the boy, about five months later, there was divergent strabismus of the right eye. Eccentric vision = $\frac{15}{200}$. Jaeg. 12. Optic disc opaque, pale, with atrophic excavation. Arteries very thin; veins normal; ecchymotic spots resorbed. The hemorrhagic extravasations on the border of the optic disc and on the nasal half of the retina somewhat yellowish, but in all other respects unchanged.

Case 4.—C., grocer's son, ten years old, suffering from whooping-cough, had a violent fit of coughing in the night of July 13th, 1880. On the following day he noticed a curved black line in the visual field of his right eye; besides, the objects seemed slightly crooked and not so distinct as they had been before. There were numerous blood extravasations on the lids and the eyeball, which spontaneously disappeared.

Examination, made July 23d, showed—

Right Eye.—Media clear. Pupil slightly contracted, of fair reaction. The lower half of the anterior chamber is somewhat shallow, which is caused by the bulging forward of the lower part of the iris. The upper part of the iris is slightly tremulous. The ophthalmoscope reveals nothing abnormal, while the pupil is contracted. After the latter had been completely dilated, the ophthalmoscope shows the upper border of the lens as a dark curved line, and diplopia of the optic disc and the vessels. There is V = $\frac{20}{40}$. Jæg. 3. No monocular diplopia. Cylindric glasses do not improve vision.

Left Eye.—V = $\frac{20}{15}$. Jæg, 1. We had to deal here with a subluxation of the lens, caused by the partial rupture of the zonula Zinii, which took place in consequence of the commotion of the eyeball by the violent fit of coughing.

1912 *Arch Street.*

REMINISCENCES OF A VISIT TO EUROPE IN 1879.

BY LAURENCE TURNBULL, M.D.,
Of Philadelphia.

VIENNA, September, 1879.

On Friday and Saturday suffered much from the effects of the dust and damp of this region, which was before referred to, and had a most severe attack of influenza, in spite of the use of large doses of quiniæ sulphas, gargle of chlorate of potassium, etc. The discharge was so profuse that I had to plug my nostrils with cotton, a plan which was found of great use in protecting the irritated mucous membrane. On Sunday was able to dine with Professor Gruber, but not well enough to make an excursion to the Austrian Alps with Professor Politzer and a party of friends. Spent some time with the latter, seeing his practice in his private office, and also examining a large number of normal and pathological preparations. The latter were very instructive, and numbered over forty. The normals ones numbered about one hundred. There was an interesting case in his office, a lady patient, in whom he had performed perforation of the mastoid process, with success, last November. Two of the pathological specimens were interesting to me in this connection, as the mastoid in one had been perforated during life, and in the other after death. In the first, the bone was very thin and spongy, and had allowed the instrument to penetrate too deeply, while in the other specimen the whole petrous portion of the temporal bone had been diseased, and had a loose sequestrum in the centre of it, which could only have been removed by a most extensive operation; but before this was attempted the patient died, from blood poisoning. It resembled a specimen in my own collection, presented to me by the late Dr. Halsey. There was also a preparation of the normal Eustachian tube, varnished, prepared with carbolic acid, after the plan of the Professor of Anatomy of Geneva (which I described in my letter from that city). Professor Politzer stated that the muscular portion was two and a half centimeters, while the bony portion was only one half centimeter in length. I inquired about the use of bougies in dilating the tube. I found, like us, he employs the ordinary form, of varnished silk, of the French, but in many instances he finds it necessary to employ those of whalebone, rounded and very fine. I made an engagement to meet him on the following day at the University, to be present at his clinic.

After dinner Dr. Gruber invited me to go with his wife and children to the Prater, it being, by the way, one of the finest days since my visit to Vienna. So we all went, in the cars, and when we arrived he would have me go in with him to see the rotunda of the main building of the Exposition, which he stated was a pecuniary loss to Vienna of 20,000 florins, owing to the excitement and a slight attack of cholera which then prevailed. In this building was the celebrated "Blondin," of Niagara fame; he had a wire rope across the immense building, and he and the persons in the upper parts looked like pigmies. There were 15,000 persons in the building. He not only walked across, but carried a stove on his back, lighted it, baked a cake, ate part of it, drank wine, and then sent down the balance to the audience, and started across with the stove burning and smoke coming out of the pipe, until he arrived on the other side. The distance was 250 meters, or about one fourth of a mile. We then went all about the Prater, and found the place filled with every conceivable kind of amusement—concerts, etc. I then took a carriage, saying good-bye to them.

This morning, according to appointment, went to Prof. Gruber's house at a quarter to nine; it was raining; he called a cab, and we soon arrived at his private room, where we left our wraps, and passed through a crowd of patients to the clinic room. The Professor and his assistant immediately went to work. The book of registration contained several items not on our book at Jefferson College Hospital, as, for instance, a line for special hospital cases in the wards, the whole number of which, up to that morning, since the middle of 1861, was 1629; then there was a space for the new patients, etc. I send you the form and the ticket which each one must bring with them. The very first case happened to be one of perforation of the membrana tympani, and he began by showing me his punch, by which he can make artificial drums out of any kind of material. He first determined the hearing distance, which was three centimeters; he then tried with a piece of linen, and this increased it to double; not satisfied, he tried India rubber, gold-beater's skin, court plaster, but none did so well as the simple muslin, which he likes very much, as he can put on it ointment of any kind. In a second case, a young girl, he tried the rubber cloth, and shortly her hearing power was increased from 2½ centimeters to 30. He showed me several cases of hypertrophic enlargement and thickening of the drum, and also thickening of the posterior folds, which thickening he treats by free injections into the

middle ear, with tepid solutions of sodium carb., until it bulges outward, and gets into the thickened masses of the membrana tympani, when he perforates the membrane with advantage. In an acute catarrhal inflammation of the middle ear he employs preparations of gelatine and glycerine, morphia, one-tenth of 100 grains, and various other agents, which, he says, not only relieves pain, but improves the otorrhœal discharge. They are like a little bottle in shape, and if they do not dissolve, which they should do in almost every case, he adds a little warm water; but if properly prepared they will dissolve in a few minutes. After seeing some 25 or 30 cases of every variety of diseases of the ear, he passed into his private room again, and showed me some fine normal specimens of the anatomy of the ear, and dwelt upon his discovery of the cleft or opening through the mastoid process, the microscopic illustrations of the various bands of the membrana tympani, also the cartilage which is found in the joints of the malleus, etc. Then a most interesting case of caries in a little girl, covering all the mastoid process, with a large sinus running through it. She got well, leaving a large opening. Another case of exfoliations of the cochlea entire. Another, of a patient whom he had operated on for mastoid disease with success, but who died of dysentery, and he procured the bone. Also, an extensive case of caries, showing the nerves, etc., this patient dying with tuberculosis. He then went with me to "Leiter's," and we got three mirrors, a cutter, a pair of forceps, and syringe, for use with the catheter. Gruber's instrument for removal of adenoid growths is more sensible than anything I have seen; all others are either scrapers, or too heavy in form for use for children.

My opinion is that the diseased condition of the post-nasal space termed "adenoid growths" is not as frequent as it was supposed to be by Dr. Meyer, of Copenhagen, who was the first to draw attention to the disease, in a paper published in October, 1869. In the clinic of the University of Vienna Dr. Gruber had no case on his list. I went to Paris and met Dr. Lœwenberg, in consultation. I most certainly thought this gentleman, who published an exhaustive treatise on the disease, would be able to show me a number of cases; but in three visits to him he was unable to show me a single case. Again, when I went to Edinburgh I was most kindly invited to visit the Ear clinic of the Edinburgh Royal Infirmary, by the surgeon in charge, Dr. Kirk Duncanson, and was much interested in his cases, but he had no case of this disease. In London, Dr. Mackenzie showed me every attention, and also gave me a note to his chief assistant, Mr. Mack Hovell, who is medical officer and registrar of the Hospital for Diseases of the Throat and Chest, with its tens of thousands of cases; and in all their large number of instructive cases, of which I examined over one hundred, there was but one case of "adenoid" disease in the hospital, and this one had been operated upon by Dr. Edward Woakes. In our own clinics at the Howard and Jefferson Hospitals the number of cases of this peculiar form of disease have been very few—say, from 1879 to 1880, not more than *three* well defined cases. There are numerous cases of hypertrophic development of the granular structure and acinose mucous gland, but no pendulous projections; but these are very different from a case of "adenoid" disease, which is made up of growths varying in size from a pea to some as large as a pigeon's egg, and when the finger is placed back of the soft palate they resemble an irregular, soft, pendulous mass, and are aptly compared by Dr. Meyer to a "bunch of worms." Opportunities of seeing true cases are rare, and when only known by a description we are apt to confound them with the form of post-nasal catarrh associated with chronic inflammatory enlargement of the *pharyngeal tonsil* which occupies the vault and a portion of the posterior wall of the pharyngo-nasal space. It is to the researches of "Luschka" that we are indebted for the most complete description of this organ, and to Dr. Andrew Clark, of London, who, in the London Hospital Reports of 1864, accurately described the disease, and who also proved that the secretions, when healthy, had the power of converting starch into sugar and assisting in digestion. We fully believe that the tonsils are placed there to assist digestion, and when healthy perform their function up to the age of thirty; after that time they are not as active, and then reduce in size.

Benzoate of Soda.

According to Müller, of Breslau, in *La Presse Médicale Belge*, benzoate of soda has no action on bacteria, and does not prevent infection. It conducts itself very much the same as salicylate of soda. These salts have neither antiseptic nor antiputrescent properties, while benzoic or salicylic acids have these properties in a high degree. The action of these salts varies considerably, according to the plan of absorption. In the stomach they are decomposed by the hydrochloric acid: salicylic acid and benzoic acid are set free, and may act locally as antiseptics.

Hospital Reports.

BELLEVUE HOSPITAL, N. Y.

CLINIC OF AUSTIN FLINT, M.D.,

Professor of Principles and Practice of Medicine in Bellevue Hospital Medical College, New York.

Insolation.

I wish to call your attention first, to-day, gentlemen, to this patient. It is a case of insolation, or sunstroke. The oppressive and unprecedented hot weather at this season has produced quite a number of cases of sunstroke. Only two cases, however, have been received into this hospital. One case terminated fatally a few minutes after admission. This is the other case, which was transferred to the third medical division. This case, I am happy to see, is apparently doing exceedingly well. It is a rather typical case, I think, after looking at the history, of insolation proper, or thermal fever, if you choose to call it so. It is an essential fever, evidently. Let me say that cases of so called insolation are of a somewhat diversified character, and practically it is very important to make a discrimination among the cases. The very typical cases are cases of sudden coma accompanied with high fever and frequently a very high temperature. This case, as we shall see, had quite a high temperature. These are the two more important criteria of thermal fever, or a true case of insolation; but during the prevalence of heat patients frequently become exhausted, and they lose consciousness suddenly from pure exhaustion, and they are brought into the hospital. In these cases we do not find the high temperature; we do not find the forcible pulse or the strong action of the heart that we do in the cases of thermal fever; and it is very important not to treat these cases in the same way as we would treat cases of a different character. Perhaps the majority of cases come within these two conditions. Then there are cases (but I do not know that these should be separated from the cases of thermal fever) in which we have developed very quickly all the symptoms of acute cerebral meningitis; and these are to be treated as cases of acute cerebral meningitis. And we have other cases where, in addition to a high temperature and a strong pulse, we have the symptoms which denote active cerebral congestion; and these cases, I think, should be discriminated, for I have been led to the conclusion that in these cases prompt venesection is indicated, and we may be able to save life by resorting to it. I think I have seen at least one life saved by a prompt resort to venesection. With reference to the use of that treatment, we should certainly make a discrimination between cases where the symptoms are those of exhaustion and cases where the symptoms are those of cerebral congestion.

Well, now, the history of this case has been taken very carefully, and will be instructive, I think, as giving you a good picture of a case of thermal fever or insolation, febrile phenomena being prominent. The patient's name is August O., a German, forty-five years of age, a tailor by occupation.

In speaking of cases of insolation which may occur during this hot weather, I meant to have referred to the importance of discriminating between cases of insolation and cases of alcoholic intoxication. A considerable number of the cases brought into the hospital during the time cases of insolation occur are cases of drunkenness; of course we are to make that discrimination.

This patient was picked up in avenue A in a comatose condition, and when admitted, at 8.50 P.M. yesterday, he was still comatose; the breathing stertorous and labored, the skin dry and hot, the eyelids closed, the pupils contracted; the temperature in the axilla was 106°. I have known it to be 110 in a case which recovered under treatment. The pulse 160, full, incompressible; involuntary evacuation of the bowels; he vomited once. The lungs were examined, but presented nothing abnormal.

This was the group of symptoms when the patient was admitted. The treatment consisted in putting at once the ice bag upon the head. Then he was put upon what is known as Kibby's cot, which is a cot so constructed as to allow of a very convenient application of cold water, or warm water, as the case may be, to the whole body, and he was bathed with cold water. He had dry cups applied to the chest as a prophylactic measure. We know that one of the conditions incidental to insolation is pulmonary congestion. This was done, then, immediately after his admission into the hospital, and he was admitted at 8 o'clock and 50 minutes last evening. It is important to take note of the time here, so as to judge of the efficacy of the treatment. At 9.30 the temperature in the axilla was reduced to 102°—from 106° to 102°—by treatment with water. He had then a cold water enema. At ten o'clock, half an hour later, the patient was evidently improved; he opened his eyes; the pupils were more dilated; he starts, gasps, and shivers when water is poured upon him. The breathing now is less labored and more natural. This shivering and starting shows an increase of reflex excitability. He now had a hypodermic of two drachms of whisky with five drops of digitalis. That was at 10 o'clock. At 10.30, the cold water being still applied, the temperature in the axilla (which is not a good guide—a point to be borne in mind, and this affords an illustration of it) gave only 101°; in the rectum, however, it gave 103°, making a difference of two degrees. He had twitching of the eyelids and mouth, and his lower jaw was noticed to move. At 1 o'clock A.M. the temperature was 101.5°. The patient is lying perfectly quiet and the breathing is easy. Six ounces of urine were withdrawn from the bladder by the catheter. It was amber in color, clear, acid, specific gravity 1.014, and contained no albumen. The latter fact is of importance, so as to exclude uræmia in these cases. If we accept cases of coma as those of insolation without due attention, there being a variety of causes for coma, it is quite possible to make mistakes. At 3.30 in the morning the temperature was 101.5°, and he had more reflex excitability. He started, and had contraction when the skin was touched. He answered questions. The arms

were flexed, and it required some force to straighten them. He had contraction of the flexor muscles of the arm. At 10 o'clock the temperature was 101.5°; pulse 108; it had a full character. The arms are still flexed. He answers questions in monosyllables; pupils do not respond readily to light; the breathing is normal, and he shows reflex irritation.

Well, that gives you a very good history of a good typical case of insolation. Here is the patient. You can see that he looks a little dull, but still he has his intellect; his eyes look well; there is a little capillary congestion, as you see; the breathing is good; he puts out his tongue readily when asked; that is one evidence of intelligence.

And now the chief indication of treatment in this case is to let the patient remain perfectly quiet; and judging from his condition at the present time, we may look forward to his improving every hour almost, and very likely to-morrow he will seem quite well, with the exception of a certain amount of debility.

Aneurism of the Arch of the Aorta.

I shall present next, gentlemen, a case of aneurism; aortic aneurism. George R., fifty-seven years of age, a native of the United States, an upholsterer by occupation, was admitted on the 10th of May. His family history is unimportant. He says he had good health up to two years ago. He has never had, so far as he is aware, any injury from a strain or violent muscular exertion, but *he has had syphilis*, and *syphilis stands in a causative relation to aneurism* in a certain proportion of cases: that is to say, a sufficiently large number of cases of aneurism in which syphilis has existed to warrant the conclusion that there is a pathological connection, and that is to be presumed in this case.

Now, gentlemen, let me say beforehand, I have not read this history; it will be fresh to me as well as to you; but we are to keep this point in view; there are the symptoms which point to eccentric pressure of an aneurismal tumor. We are often led to suspect aneurism by symptoms which lead us to think there is mechanical pressure upon certain parts, and these symptoms constitute in part the evidence upon which we base the diagnosis.

Now, two years ago, he states here, his voice became weak. Well, that is all that is stated here about that, but the mode in which it is expressed, "his voice became weak," renders it probable that it was not an affection of the voice from a laryngeal inflammation, but from some interference with those muscles which are involved in phonation, and we know that pressure upon the recurrent laryngeal nerve occurs in certain cases of aneurism and produces aphonia, or more or less dysphonia, or difficulty.

He had boring pains in the chest and back. These symptoms should always excite our suspicion; a localized pain in the situation of the aorta anteriorly or in the back. Where a patient complains of persistent pain, localized in the same spot, persisting for a considerable length of time, aneurism should always come into our minds.

He had difficulty of respiration, which may proceed from various causes; caused from pressure, perhaps, upon the trachea, or pressure on one of the primary bronchi; or from pressure on the recurrent laryngeal nerve, involving spasm of the glottis, because we may have two affections from pressure on the recurrent laryngeal nerve, namely, spasm or paralysis.

These symptoms subsided under treatment, and he felt tolerably well up to last March. Does this improvement militate strongly against aneurism at that time? Not at all, for we find cases improve sometimes, especially under certain measures of treatment, in a remarkable way. He felt tolerably well up to last March, when he woke up one morning with great dyspnœa. The voice again became weak, and he was generally debilitated, and he came to the hospital, therefore, on May 10th.

Now, on May 10th this patient was much emaciated. He had anorexia, he was weak, and now a symptom here which is an interesting one, namely, both pupils were strongly contracted, as they are now. You have here a pretty good representation of the *pinhole pupil*, as it is sometimes called. Now, it is not uncommon to have this contraction of the pupil on one side, in cases of aneurism. It is one of the symptoms dependent upon pressure upon the sympathetic nerve of the neck. It is not very common to find it on both sides, showing that pressure is exerted upon both nerves. Now this occurs from various causes. I had not long since a case of aneurism under my observation, in which that was a pretty marked symptom, and I mention this as showing the effect of perhaps too confined attention to one subject: contraction of the pupil is one of the early symptoms in cases of locomotor ataxia, and this patient was supposed to have locomotor ataxia, or it was supposed on that ground he would be likely to have it, the fact of the existence of an aneurism not then being known.

Now for the physical examination. The evidence of a tumor was found on the left side of the chest; there is dullness over the tumor; the pulsations are heaving in character, extending as low as the fourth intercostal space. The heart sounds are increased over the tumor. A systolic murmur is heard, and a thrill is imparted to the hand over the tumor. There is tenderness on pressure over the sternum. The apex of the heart is in the sixth intercostal space, within the linea mammalis. He has bronchial respiration over the right side, with sibilant and sonorous râles; bronchio-vesicular respiration on the left side, with sibilant râles.

I may state what has not yet been inserted here, that a laryngoscopical examination shows paralysis of the vocal cord on the left side, showing that the recurrent laryngeal nerve on the left side is pressed upon. The aneurism is usually on this side when the recurrent laryngeal nerve is involved. The situation of the recurrent laryngeal nerve on this side renders it more easily affected by a tumor than on the right side. His voice to-day is reduced to a whisper. It differs on different days, as it usually does in these cases, owing to the difference of pressure. That is a point of some diagnostic import, for in tumors of a different kind there is not enough variation in the size of the tumor from day to day to cause

this difference of pressure, but there is an aneurismal tumor owing to different circumstances, as pressure of the circulation, the quantity of blood, the force of the heart's action, and so on.

We have here, gentlemen, in this situation a distinct impulse; it is easily felt, and it is of considerable strength. Perhaps you can see that my hand is pressed upward. The thrill I do not perceive at the present time. You perceive that there is dullness over the tumor when we percuss. There is a systolic murmur, easily recognizable, but in itself of no diagnostic import. There is not a double murmur. I have spoken of tumors which are not aneurismal, but pressing upon large arteries, giving us sometimes a double murmur, but we by no means get a double murmur in all cases of aneurism; and moreover the cases are not very rare in which we get no murmur at all over the aneurism. The absence of a murmur is never to be taken as a point of sufficient importance to exclude aneurism. Now there is a sign here which I think is of more importance than it is the custom to attribute to it, and that is the distinctness with which the heart sounds are transmitted to the ear.. In cases of aortic aneurism that is a marked feature, as a rule; the heart sounds are very loud, near the ear. The conduction of the heart sound is such that we have that sound. We do not have it in affections of the heart, and therefore, if we exclude consolidation of the lung, that is a point of considerable importance. Both sounds are unusually distinct, so much so that formerly it was supposed the sounds were reproduced within the aortic aneurism; but that is an absurdity, they are conducted there, not reproduced.

Now we look for other signs of aneurism. We do not need any more. We do not need even as many as we have to make the diagnosis, but there are other signs which we are to look over in cases not so clear in a diagnostic point of view as this. Where there is obstruction of the trachea we have feeble respiratory murmur on both sides of the chest. When there is obstruction of one of the primary bronchi, we have feeble respiratory murmur on that side while there may be exaggeration on the opposite side And it is easy to determine whether the trachea, or one of the primary bronchi is pressed upon. When we find these signs, we should at once have our attention directed to aneurism. We should also compare the arteries in the arms, the one with the other. I do not get the evidence that this tumor presses upon the subclavian artery on either side sufficiently to affect the pulse at the wrist.

It is very easy to perceive that this tumor presses upon one of the primary bronchi. I get a well verified vesicular murmur upon the left side, while on the right side it can scarcely be appreciated. This tumor then does press upon the left primary bronchus.

Now, to direct your attention to the heart a moment. The apex is lowered; so stated in the record. Yes, it is a little below the sixth. Is that evidence of enlargement of the heart? No, because a tumor situated as is this will depress the heart somewhat, and carry the apex a little lower without the heart being enlarged. It has been contended that aneurism does not lead to enlargement of the heart, provided the heart be free from valvular lesions. I am not prepared to accept that statement. I cannot but think that the opinion generally entertained is generally correct, that aneurisms do lead, by obstruction which they offer to the circulation, to an enlargement of the heart; but they may cause an evidence of enlargement afforded by the situation of the apex beat by simply pressing the whole heart downward. So that, finding, as we do here, the apex beat somewhat lowered, we are not safe in at once concluding that we have enlargement.

Well, now, gentlemen, I have gone over the important points connected with the physical signs and the diagnostic symptoms of thoracic aneurism. Of course, I might amplify the subject considerably. But the important point, so far as the patient is concerned, relates to the treatment. In a certain proportion of cases the effect of the iodide of potassium in this affection is truly marvelous, as is true of many other remedies which have a remarkably desirable effect in some cases; we do not obtain this effect in other cases. That is true of this treatment in this disease. I have seen in my own experience quite a number of cases in which the effect of this remedy was truly marvelous. This patient is taking that remedy. He is taking ten grains three times a day. But, of course, it will be carried up to as large doses as will be tolerated; at the same time sustaining the patient by nourishing food, but avoiding an excess of food. By no means reducing him, or placing him on a reduced diet. Give him a diet ample for nutrition. I might make some remarks here upon the plan which has been proposed of late years, of absolute rest and a rigid regulation of the diet, the regulation not consisting in a reduced diet, but in an effort to adapt the diet as exactly as possible to the wants of the system. I will simply remark, that in hospital patients it is very difficult to carry that out. I have attempted it in some instances, but not with very satisfactory results.

Lead Poisoning.

I had intended, gentlemen, to bring in several cases, but as our time is limited, we shall have to content ourselves with presenting but one more. This case opens up a very interesting and important subject, namely, the varied effects of lead poisoning. They are varied, and unless we have in our minds the different effects which are referable to this cause, we are sometimes liable to overlook their influence, the patient perhaps, in the meantime continuing to be exposed to the poisoning.

This patient's name is William C., he is forty-six years of age, a native of Ireland, and his occupation of late has been working in white lead. He works in the manufacture of white lead, and inhales the vapor of it. It has occurred to me to meet with a good many cases of poisoning from lead, occurring in persons who are engaged in the manufacture of white lead, so that although I do not know all the details of the manufacture of it, still I know it involves the presence of lead in the atmosphere. It is inhaled.

He was admitted on the 25th of May. The family history has no bearing at all on the patient's disease. He has always been a hard working man, and he has been variously em-

ployed as a sailor, a laborer in iron and sugar works, but for the last four months as a laborer in a white lead factory. He has led a temperate life. He has never had gout, rheumatism, syphilis, or malaria, and has usually enjoyed excellent health. It is not very often that we have presented so clear a previous history as this case presents; in this hospital, I mean.

Three weeks ago the patient began to be troubled with vague pains in the knees and elbows. Well, now, it is pretty common to have patients complain of pain in the joints and limbs. We are very apt not to think much about it, not to form a very definite idea about it. Sometimes we cannot form a very definite idea; but there are various half neuralgic affections, as they are termed, where patients complain of these vague pains. We should have attention directed to other points of inquiry in such cases; look for other evidences of poison by lead.

He lost his appetite, as patients do when poisoned by lead; he suffered from nausea with occasional emesis. That is common. He was constipated, and that is the rule; but, of course, constipation is something common enough. He noticed that his urine was below normal in quantity, and dark in color. I am not prepared to say of how much importance that dark color may be, as indicating poison from lead. An examination of the urine was overlooked in this case, and it is usually overlooked. My impression is that the text books do not give directions for the examination of the urine. Indeed, I have reason to know so, that is, with regard to many of them, because I have had occasion to refer to some of them.

I saw a patient several years ago who had characteristic lead paralysis, but lead poisoning had not been suspected; it had not been thought of; still the patient, a child five or six years old, had wrist drop. Well, when I saw that I spoke to the physician whom I saw in connection with the case, and said I thought it was due to lead poisoning. He said it had not occurred to his mind. Immediately we made inquiry with regard to any exposure to lead, but could find no evidence of it. No others had symptoms of lead poisoning in the house. I looked for every evidence possible, and then it occurred to me to make an examination of the urine. I took it to Prof. Doremus, the chemist, and his assistant at that time examined it and brought the result to me. It was perfectly black, and showed undoubtedly the presence of lead. That it was that led me to look into works and see whether directions were generally given for the examination of the urine for lead, and I failed to find them. I do not assume to say that there are no books that contain it, but it was not contained in the books to which I referred, so that in my clinical medicine I asked Dr. Doremus to give me the details for an examination for lead, and introduced it into that work, thinking it might be useful. I do not think it is often done in order to obtain evidence of lead poisoning. I do not know how frequently we do obtain evidence of it, but I know we do in some cases, from that case I have just referred to. In regard to that case, we finally concluded that the child got lead into the system by the use of certain toys, leaden soldiers, which he played with a great deal, and which he was accustomed to put into his mouth. That seemed to be the only source of lead poisoning in that case.

You will please observe that blue line on this man's gums; the blue line on the gum which we should always look for in cases in which we have any ground for suspecting lead poisoning. It is pretty well marked in this case. I suppose it is more likely to be marked in those who receive lead into the system by the inhalation of the atmosphere coming in contact with the gums, and there meeting with the sulphide of hydrogen. But we get the blue line when it is not to be explained in that way; when a sufficient amount of the lead comes through the blood to the gums to form the characteristic blue line.

This patient became weakened, and lost considerable flesh, but continued to pursue his general vocation, however, until May 18th, when he discontinued his work, owing to exhaustion and general *malaise*. He suffered from severe frontal and occipital cephalalgia. Now, various neuralgic affections are due to lead, and when we have a case of persistent neuralgia, no matter where the neuralgia may be situated, we should think of this as a possible or probable cause. We do have in some cases, but rarely, a very severe cerebral affection, called lead encephalalgia, in which there occurs convulsions and coma, and usually a fatal termination. It has occurred to me to meet with but one well marked example of this effect of lead poison.

Now I come to another point in his history: May 19th, he was attacked for the first time with intense pain in his abdomen, constant in character, but increased in exacerbation, and situated in the epigastric and the umbilical region. At the same time he suffered very severe headache, constriction in the chest, pains in the limbs, anorexia, exhaustion, and great constipation. These symptoms persisted at the time of his admission, May 25th. Now, here we have a group of local symptoms which attended lead colic. It has received also a great variety of other names. It is characterized by pain, usually constant, but increased in exacerbation, situated, as it is here, in the epigastrium and around the umbilicus, not infrequently attended by restriction of the abdomen, unaccompanied by tenderness on pressure; indeed, pressure sometimes affording relief; and accompanied by obstinate constipation, and absence of fever. The want of tenderness on pressure, the constipation, the absence of fever, at once suffice to exclude all the inflammatory affections which are liable to give rise to colicky pain, and when we meet with these symptoms, we should at once think of lead, and direct our attention at once to the possible and probable sources of the introduction of this poisonous principle into the system.

On examination he was found to possess a well marked blue line upon his gums. Nothing abnormal was detected in any of his thoracic or abdominal organs. His urine was high colored, and had a specific gravity of 1.026; it contained no albumen. He has had no paralysis.

Well, now, what is to be done in a case like

this? What is the treatment? Constipation is a symptom which claims attention, but it does not claim as much attention, it seems to me, as it has heretofore received. It is the old practice, one of the traditional things, that patients with lead colic must be purged, the purgation kept up, and that active cathartics should be employed, as those of a milder character did not effect the object. Well, constipation is a symptom which claims attention, of course, but I do not know that we produce any marked impression upon the disease by overcoming the constipation. We should endeavor to secure such an evacuation of the bowel as to prevent any inconvenience from that cause. Aside from that I do not know that the use of cathartics effects any very important object. However, of course it claims attention. And at the same time the pain is to be relieved. If the patient is suffering extremely from pain, it is important to relieve it, and these objects conflict with each other. We cannot well give cathartics and opiates at the same time, as one neutralizes the other. However, we can effect something if we do not give our opiates in too large doses.

This patient, gentlemen, does not belong to my division, but the treatment has been as follows: he was put upon the sulphate of magnesia and the camphoretted tincture of opium, of each an ounce, and water added to make a pint, and he got of this an ounce every two hours. In addition to that he was given the iodide of potassium, ten grains three times a day. For the past twenty-five years and more we have followed the observations made by a French observer, who published a monograph on the subject of lead poisoning, and gave a series of cases which seemed to show conclusively that the iodide of potassium exerted a curative effect upon this disease in this way: it formed combinations of lead in the tissues, wherever the lead might be deposited—for no doubt the effects are due to the actual presence of lead in different tissues, although it has not been exactly ascertained as yet in what tissues it especially is. But it formed combinations which were soluble, and in this way the lead was eliminated through the kidneys. And ever since that time this has been the standard remedy in the treatment for lead poisoning. Well, with regard to the effect of it, I think a good many would state that their experience accords with mine, that we do not get such evidence of its special effect as we were led to suppose we should by the above named observations and writings. At the same time, it by no means has been shown that it does not have more or less effect in that way, and therefore, especially in the absence of any other remedy at the present time which accomplishes this object, and this being the desirable object, this remedy is given; and the moment we reach the diagnosis that we have to deal with a case of lead poisoning, the iodide of potassium comes in as a matter of course.

Well, this patient has been taking ten grains of the iodide of potassium three times a day, and it will probably be increased in quantity. Now, what has been the effect of that treatment? The patient has been in the hospital only since May 25th. He says his pain has been much relieved. It was necessary to resort to the use of croton oil in order to make his bowels move, and that proved successful, and he says he was relieved by it. Well, there is one great comfort in the use of active cathartics, whether they are really indicated or not; whether they do any good or not; they are very apt to satisfy the mind of the patient. And a patient who takes a dose of croton oil is conscious of the inconvenience attending a good many evacuations, and is very apt to think that something is being done, and that that something is very likely to be useful. It has a good moral effect anyhow. I do not mean to say that that covers the whole ground, but sometimes it is not unwise to embrace that consideration in prescriptions.

Well, that is the case, gentlemen; a well marked case of lead poisoning, and it is a case which shows so far the good effect of the treatment which has been pursued, and which is now being pursued.

Editorial Department.

Periscope.

Malignant Syphilis.

Dr. Krowczynski, of Lemberg, relates the following case in *Vierteljahresschrift für Dermatologie und Syphilis*, 1 Heft, 1880:—

An unmarried woman, aged thirty, of healthy appearance and good muscular development, was admitted into the hospital on November 4th, 1875. The patient stated that her present illness began in October, and followed intercourse with a man who was afterwards ascertained to be suffering from syphilis. On examination, two indurated sores were found in the neighborhood of the commissure. Both labia were œdematous, and the inguinal glands were enlarged, hard, and free from pain. There was also a white discharge from the uterus. A lotion of sulphate of copper for the sores, and a vaginal injection, were ordered. The ulcers soon began to spread, and were dressed with powdered camphor. On the 8th of November they had united, forming a large horseshoe-shaped gangrenous sore. The inguinal glands became larger and tender on pressure. The strength decreased, and on November 20th shivering took place with a temperature of 100.4° Fahr. November 21st, temperature, morning, 101.8°; evening, 102°. The temperature remained above 101.4° until December 9th, on which day there was a violent shivering fit, with headache, pains in the limbs, and general malaise. The spleen was enlarged. The urine was free from albumen. On December

10th a general measles-like rash appeared. Temperature, morning, 101.8°; evening, 101°. The ulcer of the genitals remained as before. During the following six days the temperature was always below 101°. On the 15th shivering again occurred, the evening temperature being 103.5°. Next day the eruption had become papular, the papules being about the size of a lentil. The temperature during the following ten days fluctuated between 100.4° and 101.4°. On December 25th there was a third attack of shivering, the temperature rising to 103.5°, and a red halo was noticed round each papule. Vesicles and pustules now appeared on the skin, and the temperature fell to 100.8°. The pustules ruptured, and left small ulcers. On January 15th, 1876, the ulcers were of the size of half-crowns, but the general condition had slightly improved. The genital ulcer remained as before as to size, but was cleaner, and granulations were springing up at the edges. The patient from this time improved steadily; the temperature fell to 100°. The appetite returned, and the ulcers on the body began to heal. On March 27th the primary sore was healed. On April 3d syphilitic patches on the palatine arch were noticed for the first time. The ulcers of the skin healed, but left raised hypertrophic scars, which soon afterwards broke down into ulcers. The subsequent cicatrization occupied some time. No further relapse took place after this; but the patient remained in the hospital until January 4th, 1877, by which time she had completely recovered. The man from whom she had contracted syphilis was now traced, and was found to have suffered very mildly, condylomata on the genitals and in the throat having been his only symptoms.

Hemlock in the Treatment of Cancer.

Henry Kennedy, M.B., of Dublin, writes as follows to the *Lancet*, August 28th, 1880:—

At present, when the profession are in expectation of getting a cure for this frightful disease, it has seemed to me advisable to call attention to a remedy which used to be in great vogue, but which has most unaccountably fallen into disuse. There is nothing, indeed, in medicine more remarkable than the fact of the way in which medicines, patent medicines, too, are forgotten or thrown aside. Into the causes of this I am not now going to enter, but simply to state a well-known fact. The medicine I would now recall to notice through your widely read pages is the well-known hemlock; and in saying this I am well aware of Harley's most valuable observations on this very drug. But it is as a remedy for cancer, in some, at least, of its forms, that I would here speak of it. Now, sir, the evidence of the power of this medicine over cases of cancerous disease is very great indeed; and that man would do well to the profession who would simply make out a list of the cases where it has been so employed. Not that every case was bettered by its use, for this is not to be looked for, but that the majority were. It will be observed that I used the word "bettered;" as, if I said "cured," it would be at once concluded what I advanced would not be worthy of a moment's consideration; though certainly there are plenty of cases in which a complete cure was effected; and this in cases of what seemed both open and occult cancer. This evidence, it appears to me, seems quite sufficient to authorize us to fall back on the remedy. It has been objected to the use of hemlock that its preparations are uncertain, and do not contain the active principle. Granting that this is true, in a degree. it is certainly no reason for giving up its use. But I think that, with such a formidable disease as cancer, it would be well to use the hemlock which grows in other climates than Great Britain; for there can be no doubt that it is a much more vigorous plant abroad than among ourselves; and indeed the parties who first introduced it in Germany enter into particulars as to the locality in which it grows and the time of the year it is to be plucked, which prove their opinions on the matter.

The dose of the drug in common use, I may state once for all, is too small. The British Pharmacopœia puts down the dose of the extract at from two to six grains, which is totally useless. To an adult not less than ten grains may be given; and I find a very suitable way of giving it is in an eight-ounce mixture, of which half an ounce, by measure, may be taken three times a day, each dose containing ten grains, which can be readily increased, and which will be needed in such a disease as cancer, for the dose must be pushed so as to produce its physiological effects. I speak specially of the extract, as, on the whole, presenting the easiest mode of administration. It is not equal, I am aware, to the succus conii, either in elegance or power; but the latter has very serious drawbacks, one being its expense, and the other the quantity of spirit which it contains. Used in the way indicated, I have found hemlock a very valuable remedy. In my hands it seems to possess two distinct effects, the first being the power of allaying pain, a matter of so much moment in cancerous disease; and the second, its restorative power on the frame, as shown by the change in the appearance of the patient; and, should there be an open ulcer, the alteration for the better in the sore. I have seen no absolute cure of cancerous disease, but I have seen several cases where the disease has been beyond question kept at bay, and the life of the patient by so much bettered.

How to Feed the Sick.

Dr. E. Engals, of Chicago, makes the following remarks on the above subject, in the Chicago *Medical Journal and Examiner*, for September, 1880:—

Dr. Tanner's experiment of long abstinence from food has attracted much attention, and, judging from the tone of the daily press, I think the public deem it an idle and foolish exhibition; but in its scientific aspect it has great interest, and will doubtless be repeated by others, and we shall have champion fasters as we now have champion rowers and athletes of the diamond field and prize ring. From this we may come to give due weight to the capacity which the body has to feed upon itself, and this will lessen the fear that patients will starve, and will

help us to wait patiently for physiological repair of pathological changes. It is often remarked that truth is apt to be midway between extremes; yet public opinion goes from one extreme to another, and though we are conscious of our liability to this fault, we are generally ready to follow the pendulum through the entire arc of its motion. Within my memory the common practice was to interdict even a cup of cold water from the parched lips of a fever patient famishing with thirst. After the favorable termination of a protracted disease, when the attenuated body was clamoring for nutrition to restore what had been lost, food would be withheld to a degree that much prolonged the period of convalescence. Then came a change, and the direction of all in authority was that the sick should be "fed well." This was called "supporting treatment," and as all knew that the body was sustained by nutrition, the practice strongly addressed itself to both public and professional favor. As a consequence, patients who loathed even the thought of food and abhorred its sight were compelled to take it in considerable quantities at frequent and stated intervals, as if it were a medicinal dose. Under such circumstances food is not well digested, but is partially decomposed in the alimentary canal, and some products of such decomposition may be taken up by the absorbents to poison the blood, and the debris while retained disturbs the whole system and is thrown off by the stomach and bowels with difficulty. In ordinary sickness it is best that the patient should order his own diet list, and allow the physician to expunge from this what he judges may prove harmful. If the patient does not desire food it is generally better to leave him without it, and I can attest, from frequent observation, that this may be done with entire safety until a condition of extreme exhaustion has been reached, and even then, if the patient's desire for food does not return, stimulants are oftener indicated medicinally than nutrients. We should not forget that in sickness the digestive organs are enfeebled as well as the nervous and muscular and their labors should be proportionately lightened. It is many years since I have seen a sick person injured from having taken too little food, while I have seen many who have suffered from taking too much.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the Boston *Medical and Surgical Journal*, June 3d, 1880, contains a paper by F. R. Sturgis, M.D., on the "Affections of the Middle Ear During the Early Stages of Syphilis."

——We acknowledge the receipt of the "Report" of the Indiana State Health Commission, for 1879, containing Mortality Tables, etc., together with some excellent papers connected with public hygiene.

——"The Diagnosis of Malignant Tumors of the Upper Jaw," is the subject of a paper by L. McLane Tiffany, M.D., which comes to us in the form of a reprint from the *Transactions of the Medical and Chirurgical Faculty* of Maryland, 1880.

——Part VII of "Atlas of Skin Diseases," by Louis A. Duhring, M.D., published by J. B. Lippincott & Co., contains the following beautifully colored plates, taken from nature, with history of the cases: Eczema (pustulosum), impetigo contagiosa, syphiloderma (papulosum), lupus vulgaris.

BOOK NOTICES.

Official Register of Physicians and Midwives to whom certificates have been issued by the Illinois State Board of Health under the Act of May 29th 1877; and of Physicians and Midwives who have registered in the County Clerk's Offices under the Act of May 25th, 1877, and who claim to have practiced in Illinois ten years prior to July 1st, 1877, but to whom no certificates have been issued. Springfield, Weber & Co., State Printers, 1880. pp. 252.

This is the most complete work of its kind that we have ever examined. First, a copy of the act regulating the practice of medicine and of the board of health act is given. Then follows an alphabetical list of the counties in the State, with the physicians therein to whom certificates have been issued, giving the name, date of registry, school, residence and post office, age, nativity, total number of years in practice, and number of years in the State of Illinois; date of issue of certificate, place of graduation, or other reason why issued, date of diploma or license, and the date on which it was recorded. Then comes a list of the registered physicians to whom no certificates have been issued. Next, a list of midwives to whom certificates have been issued, with full information as to their nativity, age, number of years in practice, etc., followed by a list of those to whom no certificates have been issued. Finally, a summary and general remarks are given. A complete index is also appended.

Some of the excellent results of the acts above mentioned and their rigid enforcement, which we shall have occasion to mention elsewhere, will, we hope, cause other States to follow the example of Illinois, and purge themselves of quacks and unqualified practitioners. The Register shows that both care and labor have been expended in its composition, and we do not hesitate in saying that it is a credit to the Illinois State Board of Health.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE NATURAL HISTORY AND SELF-LIMITATION OF DISEASES.

One of the more prominent of the American Schools of thought in Medicine is that which teaches the self-limitation of diseased process as an event which cannot be retarded nor hastened, and recommends as the most instructive of all clinical investigations the observation of this process—that is, to look on and do nothing. The master of this school is the elder Flint, and he has taught his precepts for many years, but with more and more precision as he has advanced in life. Apparently he admits no exception. In a recent article he speaks of pulmonary phthisis as also a self-limited disease; the only difficulty which the observer experiences, that the cases, "by a large majority," die off before the disease has had a chance safely to reach its limit. It may be a pardonable comparison to suppose it like those steady topers who always set themselves a limit in their potations, but always get drunk before they reach the limit.

In England, Forbes wrote a popular treatise on the natural history of disease, a generation ago nearly, in which he advocated views not dissimilar from those of Flint, and on which the latter evidently has based many of his theories.

The real originator of this school was, however, Professor Schönlein, for a long while Professor in the Universities of Zurich and Berlin, a man of great influence in his day, and of profound insight into all the departments of medicine (born 1793). He taught that diseases are the manifestations of definite, regular, pathological processes, which have their beginning, progress and termination; influenced, indeed, in their outward exhibitions, by the idiosyncrasies of the subject, the character of the tissues, the environment, age etc., of the patient, but not to an extent which materially affects their progress or alters their real nature. He was the founder of what the Germans call *Die Naturhistorische Schule*, and, with various modifications and additions, his opinions are those which the authors previously mentioned have adopted and defended.

Schönlein's teachings were received with respect, and even enthusiasm, in Germany, and to this day have a very respectable following. Indeed, some of them have universal acceptance as acknowledged results of the fullest experience. The weight he always laid upon an exact diagnosis was of great benefit to the advance of that branch of science. But, on the other hand, there is little doubt but that a certain degree of neglect of therapeutic measures naturally flowed from a belief that the pathological process had a certain course to go through, which would not be much abbreviated by anything the physician could do. Hence the treatment of the Natural Historical School is eliminated down to intelligent nursing, and letting the patient fight it out. Occasional anodynes, to relieve pain, a selected diet, fresh air, repose, quiet and cleanliness, these about exhaust the resources of the physician. Anything like specifics are condemned as follies; all talk of "curing" a disease is criticised as quackery; the whole domain of "heroic medication" is relegated to the lumber room, and special formulas or combinations are laughed at as inapplicable to any disease.

This reaction against the needlessly active measures of an older school, against the lancet and polypharmacy, is far more attributable to the dissemination of Schönlein's doctrines than to those of Hahnemann, to whom it has often been attributed. The objections urged by the latter were usually trivial or ridiculous, whereas the theory of the former was highly philosophic and plausible.

That it has been carried altogether too far we think is becoming apparent. Protests against it are coming from various directions. Dr. L. F. Warner, at a recent meeting of the American Medical Association, made the following sensible remarks on the self-limitation of disease:—

"I believe that much harm has been done by doctrines widely taught in some parts of the country, one of which is the self limitation of disease, which, when fully accepted, leads the physician to feel that he has no power to cut short or limit disease. By way of illustration: Where disease commences in a case of ovaritis, and extends to the peritoneum, and is limited only when it has no more peritoneum to affect, and the death of the patient ensues. It is a fact well known by every physician of experience, that disease, instead of being self-limited, may, by a judicious course of treatment, be itself limited, as in the above case, to the ovary or a small part of the peritoneum, a quarter, a half, or two-thirds, and the patient's life saved, instead of letting the inflammation go uncontrolled and result fatally."

The study of disease as a natural phenomenon, however entertaining to the observer, is not comfortable or beneficial to the patient. The results of it are conspicuous in the mortality reports from some German and some American hospitals, where this plan is in vogue, as we have heretofore shown in this journal. The time has come when the assertions of this school need a close scrutiny and a sharp criticism. The nihilistic therapeutics they teach is a danger to the community, and the assumed impossibility of controlling disease is no sound nor satisfactory doctrine to impress on a rising generation of doctors.

—The *Chicago Medical Journal and Examiner*, July, 1880, states that the Faculty of Rush Medical College have changed the time allotted to their practitioners' course, and have announced that the lectures for post-graduates will be given in the month of April next year, after the annual winter session is completed.

Notes and Comments.

Therapeutical Notes.

DRESSING FOR BURNS.

The *Canada Journal of Medical Science*, for September, 1880, recommends the following formula:—

℞.	Iodoform,	ʒ j
	Spermaceti,	ʒ j.
	Extract of conium,	ʒ ij
	Carbolic acid,	gtt. x. M.

Sig.—Spread on some soft material and cover the burned parts.

SALICYLIC ACID IN SCARLET FEVER.

Dr. J. Murphy states, in the Peoria *Medical Monthly*, that he has found the following formula of great benefit in the treatment of scarlet fever:—

℞.	Acid. salicylis,		ʒ ij
	Mucilag. acaciæ,		
	Aquæ rosæ,	āā	℥ iss
	Syr. tolu,		ʒ j. M.

Of this mixture one or two teaspoonfuls, according to the age of the child, should be given every two hours until a favorable impression has been made on the throat and on the general symptoms. When this has been accomplished the intervals of administering the medicine should be extended to four or five hours, varying the periods as the changing symptoms of the disease may indicate the propriety or necessity of. During the existence of the acute symptoms the use of the acid should not be permitted to interfere with the sustaining treatment, which is so essential in this disease. Nor should its continued use after the acute symptoms have subsided prevent the adoption of the tonic treatment so positively required during the period of convalescence.

THE TREATMENT OF ULCERS.

Mandelbaum, in *La Presse Médicale Belge*, advises, in old ulcers of the legs, scraping, followed by the application of iodoform. When new granulations are formed, a plaster of mercurial soap may be applied, fixed by means of a bandage.

Prof. Clay's New Cancer Cure.

Edmund Andrews, M.D., of Chicago, in an article on the above subject, published in the Chicago *Medical Journal and Examiner*, for August 1880, states that experiments made by himself and others in that city would seem thus far to corroborate the assertions of Prof. Clay. But, says he, an important question arises as to whether Prof. Clay is not mistaken in giving

Chian turpentine, rather than sulphur, the primary place in his prescriptions. The malignant element in cancer appears to be the non-adherent, multiplying cells which fill its cavities, and so far as we can judge, its diastrous results are dependent on the enormous power of reproduction of these bodies. If there be a substance in the Materia Medica which can act upon these cells as antiseptics act upon bacteria, by destroying their life, or can modify their vitality, so as to check their multiplication, as arsenic checks the production of epithelial cells in scaly diseases of the skin, such a remedy will cure cancer. Cells already in existence would either be absorbed or remain harmless, if they no longer multiplied.

These cells, in short, suggest to one many analogies with such low forms of organic life as are destroyed by sulphur, arsenic, carbolic acid, etc. The analogy is vague, and not implicitly to be trusted; nevertheless it strongly suggests that the efficacy of this combination may be due to the cell-destroying power of the sulphur or of sulphurous acid, and that the turpentine may be only an adjuvant. Be this as it may, whenever we are unable to obtain genuine Chian turpentine, it would seem best, under the circumstances, to give sulphur in full doses, and to substitute the resin of the *Pistacia lentiscus* for that of the *Pistacia terebinthus*.

The *British Medical Journal* says that the Chian turpentine has been tried in the London Cancer Hospital without any success. It does not state whether the sulphur was used with it or omitted, nor whether an indisputable article of the turpentine was obtained.

Perforating Tuberculosis of the Roof of the Skull.

Dr. R. Volkmann states, in *Centralblatt für Chirurgie*, 1880, No. 1, that he has had the opportunity of observing about twelve almost typical cases of this comparatively rare affection. It consists in a process of caseation leading to melting and necrosis of the cranial bones, together with purulent separation of the dura mater, as well as of the external periosteum, which, however, always affects only one spot of the roof of the skull. A tolerably large abscess is formed externally, mostly with ill-defined symptoms; its internal surface, after spontaneous or artificial evacuation of the cheesy pus, was lined with numerous granulations containing caseous miliary tubercles, the bony tissue being also of cheesy consistence at a spot as large as a pea, often in the form of a small sequestrum, of the entire thickness of the cranium. If left alone the diseased parts heal extremely slowly, the caseous change may progress, and in many cases pus is accumulated between the cranium and dura mater. The author, has, therefore, in four cases, after freely laying open and evacuating the external abscess under antiseptic precautions, trephined the affected bone, and scraped out the dura mater, as far as it was fungous. The result has been very favorable with regard to the course of the wound. The true healing, however, was very protracted in half of the cases thus treated. The cranial integument, which had been detached by the abscess, always united directly.

Alcohol and Animal Heat.

Dr. Bevan Lewis, in a paper contributed to the *Journal of Mental Science*, April, 1880, has published some interesting observations on this subject. In opposition to the view that large doses of alcohol lower temperature by directly checking tissue metamorphosis, Dr. Lewis has found, by the use of the calorimeter, that in animals the ingestion of alcohol is invariably followed by an augmentation of the total heat formation, and that though thermogenesis may receive a slight check as a primary effect of the alcohol, the ultimate issue is invariably "the formation and discharge of a much increased heat product, often double or treble the normal amount." Dr. Bevan Lewis, however, has observed a primary check to heat formation when small doses of alcohol are given. This check was followed, when it was appreciable, by an increased heat formation, proportionate in extent and time to the size of the dose. The climax of heat formation was found to be usually coincident with the registry of the lowest bodily temperature. The restitution of bodily temperature is somewhat sudden after small doses, but extremely slow after very large ones. Dr. Lewis concludes that, with regard to the action of alcohol on animal heat, the characteristic feature is that it greatly increases the heat product, while the dispersion of the freshly formed heat is facilitated by peripheral vaso motor paresis. The author of the paper, which embodies the valuable results of many interesting experiments, lays down a notable caution regarding the simultaneous use of chloral hydrate and alcohol. He says: "The action of chloral as affecting thermogenesis being similar to that of alcohol, we obtain by their combination a most powerful vaso-motor depressant, and one which should be used with great caution."

The De Lesseps Canal in its Relation to Hygiene.

Dr. G. Halsted Boyland, in a communication to the *Independent Practitioner*, for July, 1880, on the above subject, points out that the proposed inter-oceanic canal, in order to be productive of the greatest possible hygienic benefit, both by land and sea, should be built through the most marshy and sickly part of the isthmus. Conducting large bodies of water through marshy districts, says he, acts directly upon the districts themselves, and brings about, also, certain atmospheric chemical changes. The numberless stagnant pools, sluggish streams and morasses, lying in the direct line along which the canal will be built, will be opened up and drained of their miasmatic infectious properties, while the motion of the water in the canal will not only exert a cooling influence upon the atmosphere, but vapors arising from its surface will neutralize those malarial mists so characteristic of the tropics. The sanitary benefits derived will then be twofold: 1st. Those affecting the region itself, land. 2d. Those affecting foreign intercourse, maritime.

We have not the space to enter into the forcible arguments of the Doctor, who evidently has studied the subject most thoroughly, and familiarized himself with the topography of the country, but there can be no doubt but that the effects of such a canal, with the consequent drainage of the surrounding country, would be beneficial both to animal and vegetable life, neither of which flourishes on the isthmus, when we except aquatic plants.

Correspondence.

Report of a Case of Strangulation of the Small Intestine, and a Case of Gall Stone Simulating Aneurism.

Ed. Med. and Surg. Reporter.

I send you reports of two cases, thinking that they may be of interest to your readers, as they certainly were to me :—

Case 1.—Julia W., six years of age, had been feeble from birth. When two days old she had an attack of constipation, abdominal pain and vomiting, after which the bowels moved again, and she became better. From that time on she continued to have such attacks at intervals varying from a few days to a month, rarely going longer than two weeks. Her vomiting was never fecal. As she became older, when the attacks came on she would go off by herself, preferring to be alone. She was always puny, though between attacks her appetite was good. She seemed to dislike active exercise. The only treatment that ever seemed to have any good effect was blue mass in large doses. Intestinal obstruction was suspected, though owing to the periodicity of the attacks and to the fact that the patient lived on the bank of a sluggish stream, it was thought that malaria might possibly account for a part, or, perhaps, all of her symptoms. Last June she was taken as usual, but instead of recovering on the third day, as was her wont, with a free motion of the bowels—the motion, instead of being colored with bile, was bloody—the patient went into collapse and died in a few hours. This was her history, as I learned it from the parents and the physician in attendance, when I was asked to make a post-mortem. On opening the abdomen, the whole mass of small intestines appeared of a dark mahogany color, and two or three ounces of bloody serum were found in the cavity. The small intestines adhered slightly to each other. The cæcum and appendix vermiformis were found in the angle formed at the junction of the transverse and the descending colons. The ascending colon passed from left to right across the body, doubling upon itself as it became the transverse colon, below which it lay. Below this was a hard cord, twisted from left to right, at the end of which hung the whole mass of the small intestine—gangrenous. The mass had to be turned on its axis four times before the cord fully untwisted. This proved to be composed of the jejunum on one side, on the other the ileum, and between them the axis of the mesentery. These made a flat band of from two to two and a half inches in breadth. Untwisting the cord brought the ascending colon back to the right side.

The cæcum and the ascending colon were not, as is usual, firmly attached to the right side by cellular tissue, and covered by peritoneum only on their anterior and lateral surfaces; nor yet, as occurs more rarely, did they have a meso-cæcum and meso-colon attaching them firmly to the right side, but allowing somewhat more freedom of motion; but they were completely surrounded by peritoneum, which, until it merged into the transverse meso-colon, was continuous with and a part of the mesentery. The attachment of the root of the mesentery was not, as is common, oblique, from the left side of the second lumbar vertebra to the right sacro-iliac symphysis, and about six inches in length; but was hardly half that length at the origin of the superior mesenteric artery, and transverse or nearly so. By this malformation the whole mass of the small intestine, together with the appendix-cæcum and ascending colon, hung in the abdominal cavity by a flat band six or eight inches long, with no points of attachment to hinder the band twisting on its axis, in either direction, till stopped by its own elasticity. It would seem that in the attacks preceding the fatal one the mass of intestines, by its vermicular motion, had twisted the axis of the mesentery till the bowel was closed, and then after a time had spontaneously untwisted. The fact that this twisting closed not only the lower end of the ileum, but the upper end of the jejunum as well, accounts for the absence of fecal vomiting. In the last attack the twist seems to have been so firm that it produced not only obstruction, but complete strangulation of the bowel, by more or less completely closing the superior mesenteric artery and vein. So far as I can

find in the works to which I have access, the case is unique, both in the peculiar attachment of the appendix-cæcum and ascending colon, and of the root of the mesentery, and in the extent of bowel strangulated.

Case 2.—Mrs. R., a farmer's wife, called, January 9th, 1878, to consult about a difficulty with her stomach. She was of a sallow complexion, dark hair, and quite spare. She gave the following history: She was thirty-eight years old. Her father and one sister had died of consumption. The youngest of her three children was about six years old. Two years after its birth she miscarried, since which time she had been a little troubled with leucorrhœa and backache.

Her present ill health had begun some two years since, by attacks of distress in the stomach attended with thirst and dryness of the mouth. These had continued to recur at intervals of a month or more, gradually passing off in from a day or two to a week. She did not describe it as a pain, but as a "distress;" a sense of "weakness" or "goneness," referred to the epigastrium. During the attacks the distress was not constant, but paroxysmal; there was no nausea or vomiting; they always left her weak and exhausted. Between attacks she usually felt a sense of weight after eating. Her stomach was inclined to sour and her food sometimes would regurgitate; her tongue was flat, pale and slightly coated; her bowels moved usually once in from two to four days; her urine was very scanty; often not more than from two to four ounces in twenty-four hours. I found, however, that she often did not drink more than a teacupful of fluid during the day. Her urine did not scald her, but was usually loaded with a heavy white sediment. It was not albuminous. She had been long troubled with nasal and bronchial catarrh, but not enough to seek medical advice. Her lungs on percussion were somewhat too resonant. The sternum was rather prominent, and the respiratory murmur was a little harsh. Her heart sounds were normal. The epigastrium was very tender to pressure; the hypogastrium less so. Pressure at other points on the abdomen caused pain, which was always referred to the epigastrium. Supposing the case to be one of gastric catarrh with nervous trouble, I treated it accordingly, and the symptoms improved somewhat.

On March 5th I discovered, just below the liver, at the external border of the right rectus muscle, a bulging of the abdominal wall which felt as though it were caused by a hard body, about the size and shape of a hen's egg. But as I attempted to accurately determine its size, by palpation, it slipped from under my fingers, and I could not again find it. The place where it had been was very tender, so that I could not make deep pressure, but there was pulsation and a slight thrill perceptible at that point, and with the stethoscope a loud bruit could be heard, synchronous with the heart's systole, becoming rapidly indistinct as the end of the stethoscope was moved from that exact spot. It could not be heard plainly if the patient turned on either side. I concluded that it was a case of aneurism, and treated her with heavy doses of iodide of potassium and rest, under which her general symptoms greatly improved and the local tenderness very much diminished. After this I could sometimes find the tumor, sometimes not. But when I did find it it would disappear on pressure, giving to the touch the same impression that a hard, round, slippery body does as it slides from out your grasp. The bruit and the thrill were, however, never absent.

In the fall of 1879, I removed, and the patient passed from my charge. July 2d, 1880, I received notice of her death, with a request to attend the autopsy. From her attending physician I learned the rest of her history. In November, 1879, she was again confined, and did not recover her usual health. By February, 1880, she had become very much reduced and employed a noted quack in the vicinity, under whose care she remained two months. She then employed a regular physician, who found her jaundiced, her gall bladder enormously distended, and a suspicious area of dullness at the apex of the right lung. Under treatment with nitro-muriatic acid, and after passing a number of small gall stones per rectum, the gall bladder resumed nearly its normal size. She had also at this time a cough, with purulent expectoration, both of which ceased in a short time. Her health, however, did not return. Diarrhœa with severe colicky pains and hectic set in, and she died of asthenia.

Autopsy held twenty-four hours after death. The body was much emaciated, rigor mortis well marked. The heart was normal. Cheesy nodules were found here and there on the left lung, especially at the apex. There was a small cavity in the apex of the right lung, the upper and middle lobes of which and the lower lobe posteriorly, were solidified and studded with cheesy nodules. There were no pleuritic adhesions except at the apex of the right lung; spleen and kidneys were normal. The left ovary contained a small cyst, twice the size of a pea. The omentum and both the visceral and the parietal peritoneum were studded with nodules like those found in the lung. The intestines were constricted in several places by annular deposits of like character. The largest mass, about the size of a hen's egg, was in the mesentery. To this deposit the small intestines had adhered, once in about every eighteen inches, forming a mass of loops. The liver was adherent to the diaphragm by its upper surface, which was studded with similar nodules. Its substance seemed normal. The gall bladder was somewhat enlarged, and its walls thickened. It contained a rough gall stone freely movable, elliptical in shape, one and three quarter inches long by one and a quarter wide, by three quarters of an inch thick. As I carried it to the fundus of the gall-bladder it projected considerably beyond the lower border of the liver. Holding it in this position and replacing the abdominal wall, there appeared a tumor in the same place, presenting the same characteristics both to sight and touch, and disappearing in the same way on pressure, as that I had found over two years before; there was nothing like an aneurism to be found. It is, I believe, rare to find, on post-mortem, so extensive disease of the lung where cough has been

almost entirely absent. But the principal interest of the case was in the solution it gave to a set of symptoms which during life were very puzzling. A physician of considerable experience, who saw the case with me on one occasion, when the tumor was apparent, and who also examined it with the stethoscope, agreed with me that it was probably a case of aneurism. Two or three who examined it without the stethoscope, at times when the tumor was not apparent, expressed their opinion (of course in a manner accordant with the spirit of the code) that there was not anything like an abnormal growth there. The only way that I can now account for the bruit and thrill, is by supposing that the gall-stone pressed upon some one of the right branches of the cœliac axis. L. B. TUCKERMAN, M.D.

Austenburg, Ohio, September 4th, 1880.

News and Miscellany.

Jerusalem as a Winter Resort.

The *Medical Times and Gazette* says that the European population of Jerusalem has increased of late to an immense extent, owing, in some measure, to the enthusiasm with which Holman Hunt describes the glories of the climate, and the intense interest excited by its associations. The complete success which has attended the cleansing of the streets, and the adequate supply of water, under the supervision of the German sanitary inspectors, have transformed the city from an unsavory labyrinth of mud hovels to a picturesque Eastern town, with cooling fountains and clean white dwellings, adorned with verandahs and abundance of sweet-smelling creeping plants. It is suggested that the Holy City may become a winter resort with the fashionable, in place of Rome.

Anæsthetics in 1651.

The *Lancet* informs us that in a recent work, entitled "Histoire de la Médecine à Troyes," Dr. Guichet relates that the College of Physicians of that town brought an action against a certain Nicolas Bailli for administering internal remedies to his patients and *putting them to sleep*. In defence Bailli declared that having observed that in great operations, amputations, incisions, actual and potential cauterizations, many patients slipped through his hands for want of sleep, he had studied the secrets of nature, and had at last found a cordial, or marvelous essence, which put them to sleep softly, and appeased their sensibility to pain.

The Night Medical Service.

The *Medical Record*, September 4th, 1880, informs us that the Night Medical Service in New York is now in full working order. The number of precincts in the city is thirty-five. The number of physicians who have been registered for duty on the Night Medical Service is 329. This represents all the applicants for registration with one exception. The exception is that of a physician who was implicated in a recent criminal prosecution.

Reported Cholera in Russia.

Russian journals report an outbreak of "cholera" at Saratov, on the Volga. The scanty particulars given suggest that the report refers to an outbreak of choleraic disease, probably caused by the consumption of some poisonous article of food, after the manner of the recent fatal choleraic outbreak at Welbeck.

Buchanan Captured.

Dr. Buchanan, of bogus diploma fame, who, it will be remembered, leaped, or pretended to leap into the water from the deck of a Delaware ferry-boat recently, in order to create the impression that he had committed suicide, has been captured in St. Clair, Michigan.

OBITUARY NOTICE.

—Professor W. T. Wythe, M.D., died at his residence in California, June 26th, aged thirty-three. He had for several years occupied the Chair of Anatomy in the Medical College of the Pacific Coast, and was much esteemed by his fellow physicians.

QUERIES AND REPLIES.

Dr. H. L. C., of Ohio, requests some one to give him a sure remedy for eczema rubrum of the forehead and face.

Dr. J. M., of Indiana.—1. No, certainly not. 2. We refer you to an article on the subject, by Stephen V. Crooks, M.D., of Lake, Indiana, which appeared in THE MEDICAL AND SURGICAL REPORTER for July 12th, 1873.

MARRIAGES.

EARLE—VESEY.—On August 26th, 1880, at the residence of the bride's parents, Ellerslie Place, near Petersburg, Va., by the Rev. Mr. Logan, Frank M. Earle, M.D., of Philadelphia, and Mary E. Vesey, formerly of Philadelphia.

EYRE—GAUSE.—On September 1st, by Rev. E. D. Fendall, Frank Eyre, M.D., and Jessie, second daughter of O. B. Gause, M.D., all of Philadelphia.

GEIB—LEEDS.—On Monday, September 6th, by the Rev. T. T. Munger, North Adams, Mass., Dr. Henry P. Geib and Jennie C. Leeds, both of Stamford, Conn.

HURLEY—HART.—In Trenton, N. J., August 31st, 1880, by Rev. D. Stewart, Dr. Lewis P. Hurley and Miss Abbie S. Hart, both of Hopewell, N. J.

LOUGHRIDGE—EDWARDS.—At Danville, Ky., September 1st, by Rev. Dr. J. Edwards, Samuel O. Loughridge, M.D., of Peoria, Ill., and Effie M. Edwards, daughter of the officiating minister.

TAYLOR—COLLORD.—In Cincinnati, Ohio, on Tuesday, the 24th ult., William H. Taylor, M.D., and Helen Rebecca, daughter of W. A. Collord.

WILEY—TITLOW.—September 9th, at the residence of the bride's mother, Norristown, Pa., by Rev. Robert Adair, Dr. S. N. Wiley and Miss Mary E. Titlow, both of Norristown, Pa.

DEATHS.

CASTLE.—In New York City, on Tuesday, August 31st, Dr. A. C. Castle.

THORNE.—On Wednesday, September 1st, 1880, at his residence, No. 51 Sands street, Brooklyn, N. Y., Dr. J. Sullivan Thorne.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1230] PHILADELPHIA, SEPTEMBER 25, 1880. [Vol. XLIII.—No. 13.

Original Department.

Communications.

BELLADONNA IN DISEASE.

BY H. N. BURR, M.D.,
Of Palmyra, N. Y.

The use of this remedy for the relief and cure of disease has been full of interest to me since I have come to use it more freely than I did in former years; and in its use I have found it to give as good satisfaction as any remedy of the Materia Medica. The success attending its use has been such as to beget in me great confidence in its power when administered for certain diseases; and that it has control of certain diseases, to that extent that it might almost be called a specific for them. The use of it has led me to look up its record in our standard works on materia medica and therapeutics, and I find its description and application does not embody all its virtues nor all of its powers for controlling diseased conditions of the system. Prof. Wood's work on Therapeutics and Pharmacology would not lead us to have much confidence in it, in but few diseases, and in some of them he does not recommend it very highly. In the treatment of neuralgia of the head and face he gives it with full confidence in its power to control and relieve the pain. The varied accounts given of it in our many journals ascribe to it superior powers, and as a remedy deserving of our entire confidence and a prominent place in our prescriptions and in our medicine chests. Its virtues are not as fully understood and appreciated by the profession generally as in my judgment it should be, having met with those who never used it in all their practice. I remember one who had been in practice over forty years who said to me that he had never used it; that he never met with a case where he found it necessary; that he did not think much of it as a remedy; and further, that it was such a dangerous remedy that he was afraid to give it for fear he would give too much and poison his patient.

Belladonna is classed by our standard writers among the anodynes, narcotics, and cerebral stimulants. Prof. Wood places it in the latter class, and by the side of opium, hyoscyamus, and camphor. Its narcotic power is seen when given in large doses, and when it becomes a poison. Its virtue as an anodyne is upon certain functions and organs, as the uterus, the several sphincters, and the nerves of the head and face. That it acts upon the whole system as an anodyne, in the same general manner that opium and its preparations do, I am not prepared to admit; nor does its more extended use for other affections than those mentioned by our standard writers tend to the confirmation of its being a general anodyne. If I might use the term, I would call it a special anodyne, since its greatest power is seen in its control of certain affections. I have not found it to act as a cerebral stimulant in my hands, but on the contrary, to have a quieting and sedative effect upon the brain. I have prescribed it when the head was hot and the face flushed, with great relief; the fullness has passed away, and the pupil has been dilated while the face would assume its natural color.

Its administration in fevers, where there has been great heat of the skin, with pain in the head and flushed face, has been followed by relief that was permanent. Its action as a sedative

has been observed in some instances where I have given it, by a marked reduction in the frequency of the pulse, from one hundred and thirty in a few hours, to ninety beats, and keeping it there during the entire course of the fever.

It has other effects upon the system than those just recorded from Dr. Wood. Its use as a cathartic has attracted much attention from medical men. Its administration alone is often sufficient to produce a cathartic effect upon the bowels, as they will move several times, with all the consistence that is observed from the action of Epsom salts or magnesia. I have known a half grain of the extract taken at bedtime to be followed in the morning by several loose stools, and free from all pain and griping. When given combined with other cathartics it greatly modifies their action, rendering them more efficient and free from those pains and gripings which often attend them when given alone. There is good authority for giving it this power in its therapeutic uses for diseases. Its action as a febrifuge is most clearly stated and established, and experience abundantly confirms it. It is a valuable adjunct in the treatment of some fevers, as the typhoid, typhus, and scarlatina. By some writers it is regarded as a specific in typhoid fever. I have been greatly pleased with its action in those instances where I have used it; it has had a controlling power over the fever during its course; under its use the fever has been interrupted, and the patient restored to health without having to go through a course. I think as an agent in the treatment of typhoid fever it should be more generally used by the profession. The antigalactic power of this drug is every year being more fully established, and its virtues better known and appreciated by the profession generally. We have been hoping that we had found the remedy that, if used in time, would relieve woman from the sufferings of a mammary abscess.

Professor Wood speaks of its effects as follows: "Belladonna produces its characteristic effect upon the system, to whatever part applied. When it is given in small doses two or three times a day, so as to bring the system gradually under its influence, the first effect usually noticed is a feeling of dryness and stricture in the fauces, soon followed by slight uneasiness or pain in the forehead, vertiginous sensations, some dimness of vision, and occasionally dilatation of the pupil." The dose must be small enough not to produce alarming symptoms, as some persons are very susceptible to its action, and a small dose will often produce its effects in a most marked degree. With children the case is different, as it has been found by experiment that they will bear a much larger dose than some adults. The dose to commence with in grown persons is one-fourth or one-half grain of the extract repeated two or three times a day. Its operation is given by most of our authors as upon the nervous system entirely; and that portion which is generally affected is the peripheral; sometimes it acts upon the nervous centres. I think it has some action on the muscular structure of some organs. Professor Wood says of its mode of operation: "One mode in which it operates is by rendering the nervous centres insusceptible of irritative impressions and incapable of transmitting irritative action. But there can be no doubt that it is capable also of operating directly upon the peripheral sensibility of the nerves, and of producing the same insusceptibility at their centres." He also says, "In the relief of painful and spasmodic affections belladonna seems to be capable of something more than a mere temporary influence. Not only does it give ease, but by a perseverance in its use we not unfrequently obtain positive cures from it, which opium itself, though more powerful as an anodyne, is unable to effect." The manner in which it affects certain organs may be explained in its peculiar action upon certain parts of the nervous system and upon unstriped muscular fibre. It has for a long time been used to dilate the pupil and to relax the neck of the uterus in some cases of labor. When given for constipation it has the effect to relax the bands around the large intestines and the sphincters of the rectum, and by that means the fecal mass is carried along by the natural action of the intestine. In this case its action, no doubt, is upon the peripheral portion of the nerves, rendering them insusceptible to the irritative impression of the hard substance in contact and pressing upon them. The same writer says of its contraindications, "They are active congestion or inflammation of the brain, inflammation of the stomach, high inflammatory or febrile excitement, and a plethoric state of the system. In all such affections, should the remedy be called for, it must be preceded by depletion. Its indications are: 1st, to subdue pain; 2d, to relax muscular spasm and rigidity; 3d, to stimulate the nervous centres; 4th, to lessen the sensibility of the retina and dilate the pupil. As a soporific it cannot be relied on."

We come now to speak of its application in the treatment of disease, and we will treat of each class by itself, and introduce such illustrations as

may bear upon them. When used to subdue pain, it is in those affections which are neuralgic and where the periphery is the seat of the pain, and not so much when the pain is near the nervous centres. Its application for the relief of neuralgia of the face and head has been attended with entire relief in many cases; while some relief is given in almost every case where it has been used. When used for pain in the scalp it is given internally, and the infusion is applied to the part by saturating the hair. The infusion consists of one half ounce of the leaves in a pint of boiling water. When used for the face the lotion is made by dissolving the extract in water and applying it to the seat of the pain, when relief will be afforded in a short time. It must be repeated once in three or four hours, in order that its effect upon the nerves may be continued. When faithfully persevered with it will sometimes cure the neuralgia. If given internally we get the same effects, but the relief is not so decided as when used locally. For some painful affections of the eye it may be used to relieve pain and procure rest, when nothing else will. In those affections of the bowels where there is great pain from different causes, relief may be obtained by the use of belladonna much quicker than from opium.

It has proved very beneficial in colica pectonum in connection with other treatment, as it will relieve the severe pain and aid in the action of the cathartic, and a cure can be effected much sooner than where it is not given. Its action in this case being upon the muscular coat of the intestines, which have become filled with hard fæces from the constipating effects of the lead. This acts as an irritant to the peripheral extremity of the nerves, and induces congestion, which increases the pain and adds to the suffering by the spasmodic efforts of the bowel to throw off the hardened contents. The fæces are dry and hard and there is not power enough in the bowels to move it forward. The belladonna acts upon these small arteries and contracts them, preventing an excess of blood, which acts as a stimulant to the muscles to get relief from the irritative contents; the peripheral portion of the nerves is rendered insusceptible to these impressions, and pain is relieved; the muscles of the intestine respond to the action of the cathartic, and the bowels are able to move the fecal mass along, so that relief is obtained. In support of its use in lead colic, I quote from *Braithwaite's Retrospect*, No. 24, page 116. Dr. Malherbe says of the belladonna treatment, "On the first day give five centigrams of the extract with ten centigrams of the powder of the root. When the first dose is without effect, that is to say, when neither the pains nor constipation have diminished, the second is composed of ten centigrams of the extract and twenty centigrams of the powdered root. At last he has gone as far as twenty centigrams of the extract, with forty of the powder; but has not carried the dose further." With this treatment the greater number of his patients have been relieved from the first to the third day. In cases which have offered great resistance and were not relieved by opium, belladonna has succeeded. In enteritis it is much to be preferred to opium to relieve the pain, as also in dysentery.

It has been used in cholera morbus and brought relief when opium had failed. In the *Pacific Medical Journal*, Dr. Whitehead says, "My first case of cholera morbus, opium having failed to relieve, I ordered one half grain of the extract of belladonna, in pill, every four hours. The first pill relieved the sense of constriction, or knotty pain from the region of the umbilicus, and after the third pill the bowels were freely moved, although several purgative draughts had been taken without effect. After having taken two grains of the extract the patient rapidly recovered, with no constipation, headache, or unpleasant symptom. The same treatment proved successful in three other cases."

In bilious colic the hypodermic use of small doses of atropia give relief much quicker than morphia, at the same time it aids the action of the cathartic. After the first dose the stomach becomes retentive, and other remedies have a chance to do their part of the work.

As a remedy in erysipelas and inflamed chilblains, boils and carbuncles, it has been used by some physicians, and very highly recommended. These affections are treated with it locally, using the tincture to apply to the seat of pain.

In angina pectoris the belladonna plaster will usually afford relief and effect a cure. In combination with camphor it has been used with some success for the treatment of dysmenorrhœa. In some cases it has been found to give relief when other means had failed. I can bear testimony to its virtue in this trouble, having seen patients pass from excruciating suffering to entire relief under its use. It has more power over the actions of the uterus, to control the spasms and relieve pain, than any of the anodynes which I have used. Its administration for a few days at a time was successful in one of my patients, in relieving the morning sickness attendant on gestation. During the preparation of this paper I was called to see a

severe case of colic, where the friends had tried to get a passage from the bowels with cathartic pills, and had failed, the stomach being unable to retain them or anything else. He was suffering very severely when I saw him, the stomach sore, the bowels tympanitic. I used the belladonna in order that I might test its power to relieve him. I gave him first fifteen drops of the tincture, which was retained, and in half an hour he began to feel better. In an hour I gave him one half grain of the extract, followed in two hours with two teaspoonfuls of Epsom salts. These were retained, and he was soon free from the pain which he had been suffering. I ordered the belladonna to be given every four hours, with a teaspoonful of salts. I was to have visited him the next day, but his son came to tell me his father was well, having had his bowels freely moved during the night.

In gastralgia and acute nephritis it is of service in relieving pain and relaxing spasms. Its power over spasms and muscular rigidity makes it an important medicine in a good many diseases where this condition is found. In retention of urine from spasmodic action, caused by irritation at the neck of the bladder, this remedy taken internally, in small doses often repeated, has been found to give relief when others had failed. It has long been the standard remedy for incontinence of urine. Some physicians speak of it very highly for this complaint, while others speak disparagingly of it. The reason for non-success has been in using the medicine in too small doses. As a remedy in whooping cough it was used in ancient times, but fell into disuse until revived by Bretonneau. In this country it has been employed by Dr. Samuel Jackson, late of Northumberland county, and very highly recommended; he gave from one-sixth to one-twelfth of a grain of the extract to a child two years old, three times a day, until the pupils became dilated. Dr. Hiram Corson, of Montgomery County, Pa., has used it with great success. Prof. Wood says he used it in but one case; he applied the extract to the chest of an infant who had whooping cough. The child was taken with convulsions that were repeated and alarming. The child recovered from them and the disease was cured; he never used it again. Brown-Séquard says "whooping cough can be cured in three days by its use. But in order to do it the physician must stay by and watch its effects." Dr. B. S. Woodworth, of Fort Wayne, says that during a practice of thirty years he never knew it to fail to cut short an attack of whooping cough in a week or two.

Its use in asthma is highly recommended by Dr. Hyde Salter, in the London *Lancet*. He even goes so far as to call it a cure, if persisted in. He commences by giving ten drops of the fluid extract at bedtime, and increasing the dose every night until its specific effects are felt. He has given as much as forty drops at one dose, with the effect of preventing the paroxysm entirely. He thinks when used in this way, it will be a prophylactic. By some it has been asserted to cure epilepsy.

Within a few years it has come into use for the treatment of obstruction of the bowels from impacted fæces. Dr. Fleming, of Birmingham, having used it successfully in a number of cases which have come under his care, both for obstruction and for constipation, speaks of its action as follows: "The ordinary irritant purges provoke increased secretion and peristaltic action of the gut above the obstruction; this may succeed in propelling the accumulation forward, but should it fail in so doing, we have inverted action and vomiting, with the further risks of enteritis, and general, and it may be fatal, exhaustion of the patient. Atropia, on the contrary, operates through the blood on the entire canal; acts directly on that part of the gut which is distended by the accumulation, and so paralyzed. Deprived, by the drying qualities of the drug, of its natural coating of mucus, the mass more readily provokes irritation; the natural contractile action is re-established, and the bowel is more or less quickly relieved of its contents." For the relief of constipation, he gives a saline draught at bedtime, composed of magnesia sulphate one drachm, aromatic sulphuric acid, ten minims, tinct. aurantii, one drachm, and one ounce of water, and the same in the morning; into the evening dose, he drops one-sixtieth of a grain of atropia in solution. This amount is increased two minims every night, until the throat becomes dry and the pupils dilated, and dim sight is produced; after this the dose is lessened but continued for several weeks, when he substitutes strychnine for the atropia, and continues until a cure has been effected. He uses the same remedy in obstruction, only repeating the saline several times during the twenty-four hours. Acting upon that idea, I have used the extract of belladonna in the same way, and given one teaspoonful of Epsom salts. I find it to be sufficient, in many cases, to procure a motion from the bowels the following morning; especially have I found it well adapted to aged people whose bowels are torpid, and in many instances the colon is filled with a mass of fecal matter.

The one-half grain of the extract will be sufficient of itself, in some cases, to insure a passage in the morning. It can be combined with other laxative remedies, to render them more efficient, and can be given to children, to relieve the torpid condition of their bowels.

As a remedy for typhoid fever, it has within a few years been put forward, and if we may credit the reports we have of its success, we may hope that the remedy has been found which will enable us to conduct our patients through a course of this fever. and avoid the many dangerous complications which often attend upon it, as the delirium, hemorrhage, ulceration and perforation of the intestines, and fatal peritonitis. I have used it in my cases of typhoid with the most gratifying results, and have had them pass through the several stages with great regularity, but none of them had hemorrhage, and in but few was there very marked delirium. I have had them delirious when first seen, but become quiet and rest under the use of belladonna in doses of fifteen drops of the tincture every four hours, and it can be continued through the whole course. Dr. Kelly, of Dublin, speaks of its action in the following terms: "It completely changes the whole character and outward manifestation of the disease. Delirium, coma and subsultus quickly vanish, and are succeeded by calmness and clearness of intellect, by natural sleep and complete control of all the voluntary powers. Diarrhœa is checked and healthy, consistent evacuation established. I am fully convinced that belladonna has more power in controlling the delirium of this fever than any remedy we now use; and I feel confident that a trial of it in this fever will convince the most skeptical of the power it has over this disease."

FILARIA SANGUINIS HOMINIS AND FILARIA DISEASE.

BY HORATIO R. BIGELOW, M. D.,
Of Washington, D. C.

I have before me the "Medical Reports for the half year ending September 30th, 1879, 18th issue, of the Imperial Maritime Customs, China," in which an elaborate article by Patrick Manson, under the above caption, is of so interesting a character to those who have followed the recent pathology of elephantiasis, that a few abstracts from it will be of service to those who cannot obtain the report. The Dr. writes: "It is true, however, that although tropical elephantiasis may be considered one of the effects of the filaria sanguinis hominis, yet we do not find the parasite in the blood in many well marked cases of the disease. This is by far the strongest argument against the parasitic theory, and demands an explanation. It is certainly not an argument fatal to the theory, for analogous facts are common enough in pathology. Once started, a varix of any sort tends to increase, though the application of the primary cause of the dilatation may have been but momentary. After reading these and similar criticisms (referring to those of Dr. Tilbury Fox), and being strongly convinced in my own mind by arguments and facts, such as others and myself had adduced, of the truth of the parasitic theory of elephantiasis, I determined to search for further, and, if possible, still more convincing evidence. It seemed to me that such evidence might be found in that group of cases which belong strictly neither to pure elephantiasis nor to pure lymph scrotum, but are either a combination of these diseases, or the transitional stage of one passing into the other. In about nine months I succeeded in finding six such cases. There is one feature which they all have in common—the enlargement of the groin glands; and directing my attention to this fact, I thought I might get some information as to the cause of this enlargement and the associated diseases, by an examination of the contents of the glands. Accordingly, I introduced the needle of a hypodermic syringe into one of the varicose groin glands of a well-marked case, and drew off, by means of the syringe, an abundant supply of clear lymph. I found abundance of filariæ in this, though I could get none in the blood from the finger. The case was one of lymph scrotum passing into elephantiasis. The filaria embryoes are described in my notes as being "very languid in their movements, one at least shriveled, the lash at the head standing out very distinctly when seen with a lower power even;" in other words, the embryoes had the appearance of being old and moribund, as if they had lived for a very long time where I had found them. * * * * * Taken in conjunction with the register of embryoes free in the blood at different times of the day, I conclude that the embryoes of filaria immitis do not die or disappear after a short existence of less than twenty-four hours, but that they rest periodically in the minutest branches of the pulmonary artery; and. that when they disappear from the general circulation they are to be found in the lungs. How they manage to maintain their position there against the blood current I do not certainly know, but I suppose they attach themselves to the inner surface of the vessels, using their oral extremity as a blood sucker.

Occasionally I have seen an embryo thus attach himself to a slide while under examination with the microscope. I think there can be little doubt that something similar happens, in the case of filaria sanguinis hominis, to what I have shown happens in the case of the embryo of filaria immitis; and that during the period it is temporarily absent from the general circulation it lies resting and waiting for sunset in some of the thoracic or abdominal viscera.

Conclusions.—By the observations of Lewis, Bancroft and others, and by those I have now and from time to time brought forward, the following conclusions are indicated.

1st. The parent filariæ live in the lymphatics; this is proved by their young and ova being found there, even when absent from the blood.

2d. They do not live in the glands, but in the lymphatic trunks on the distal side of the glands; Lewis and Bancroft found them in tissues some distance from any gland.

3d. They are oviparous.

4th. The eggs are carried by the lymph current to the glands, and being too large to pass ($\frac{1}{300}'' \times \frac{1}{750}''$), they are arrested there till hatched.

5th. After hatching, the free embryo passes along the lymph vessels and enters the general circulation.

6th. Resting in some organ during the day, it circulates during the night.

7th. Whence the mosquito abstracts it and acts as its intermediary host.

8th. In certain cases the ova or embryoes produce obstruction of the lymph circulation through the glands, either directly by their size or indirectly by causing inflammation.

9th. If the obstruction be partial, varicosity of glands and afferent lymphatics results, but by means of the anastomoses the lymph circulation is continued, carrying the embryo with it into the blood. Lymph scrotum or chyluria, or varicose groin glands, with hæmatozoa, are, therefore, the symptoms of partial obstruction of the lymphatics.

10th. If the obstruction be complete one or other of two things happens.

a. The accumulating lymph so distends the vessels that they rupture, and a lymphorrhagia results, which is more or less permanent. In this case the lymph does not quite stagnate, but being able to circulate, though in a retrograde manner, it remains fluid. The symptoms of this form of obstruction are, therefore, lymphorrhagia from the scrotum, or leg, varicose glands, and filariæ embryoes in glands, and perhaps in discharged lymph, *but none in the blood.*

b. If the lymphatics fail to rupture, there is complete stasis of lymph, and excessive accumulation in the tissues on the distal side of the glands, solidification of the glands and tissues, and elephantiasis result. The embryoes are found in the blood, as none can pass the glands, and the parent worm or worms probably die, choked, so to speak, by the stagnant and organizing lymph and their own young. Consequently, in pure elephantiasis, as a rule, no embryoes can possibly be found in the blood or gland lymph.

THREE CASES OF FRACTURE OF PATELLA TREATED ON SINGLE INCLINED PLANE, WITH SAND BAG AND EXTENDING WEIGHTS.

BY J. S. WIGHT, M.D.,

Professor and Surgeon at the Long Island College Hospital.

Reported for the MEDICAL AND SURGICAL REPORTER.

In regard to the union of a fractured patella, the following points may be noted:—

1st. The fragments generally unite by ligament. 2d. The patella is a bone in a ligamentous tendon. 3d. And as we expect severed tendons to grow together by tendon-tissue, so we may expect the tendon of the quadriceps extensor to grow together by means of tendon-tissue, when it is ruptured *at any point.* 4th. The practical objection to this new tendon-tissue consists in the fact that it can be materially elongated by subsequent use. It is not my object now to consider the question of bony union of the fractured patella, either with or without opening the knee joint.

It is desirable, in treating a fracture of the patella, to bring and keep the fragments in as close apposition as possible. In the accomplishment of this purpose, I have devised the following apparatus:—

1st. A single inclined plane is constructed, having a board bed-piece and board upright-piece meeting, and well fastened at a right angle. The end of the bed-piece that is to go under the thigh is leveled and rounded from above, backward and downward. Near the upper end of the bed-piece, on either side, is fastened, by a hinge, a quadrangular bar, that is long enough to reach to the top of the upright piece. These two bars will move up and down on each side of the upright piece. On the outside of the upright piece is fastened a hook,

over which is thrown a bandage, that is fastened by the ends to the two movable bars. A piece of muslin, or canvas, is well fastened on each side to the movable bars. This makes a kind of hammock on which to put the injured lower limb. And thus is constituted the single inclined plane, which can be raised or lowered at the option of the surgeon.

2d. Two quadrangular pieces of adhesive plaster are cut of equal size, long enough to reach from the upper part of the thigh to the middle of the leg. One end of each piece is cut into strips or tails. These tails are laid obliquely from below upward and backward, on the sides and anterior aspect of the thigh, and fastened on the thigh by means of a roller bandage, beginning at the upper end of the upper fragment of the patella, and being carried well up toward the upper part of the thigh. To the distal end of each strip, or piece of adhesive plaster is fastened a strong cord, which passes over a pulley in a crane at the foot of the bed, so as to make extension and pull down the quadriceps extensor of the thigh with the bony fragment at its lower end. I have applied a four-pound weight to the lower end of each extending cord. This makes the entire extension on the quadriceps muscle equal eight pounds.

3d. The lower fragment of the patella is attached to the tibia by an inextensible tendon, and can, by a moderate force, be held against the upper fragment, when that fragment is well brought down. To accomplish this indication, a sand bag is laid over the lower fragment, which is thereby moved *upward* on the limb, as far as possible, by the *downward* pressure of gravity, since the lower part of the limb is elevated most. The sand bag is fastened on by means of a tape, which goes around the limb. The sand bag weighs from two to four pounds.

The appliance has advantages which may be enumerated as follows:—

1st. The mechanical relations are quite simple, and can be used by any surgeon.

2d. The force of gravitation is utilized for keeping both fragments in proper place, and this is a force which never ceases to act.

3d. The patient can move about in bed to some extent; for wherever he goes, within reasonable limits, the retention forces go with him and continue to act on the fragments of the patella.

4th. The cloth on the bars of the inclined plane, on which the limb rests, will help to prevent excoriation and ulceration of the injured limb.

5th. Hence, the patient can be kept in the recumbent position long enough to obtain good union.

6th. The bandage on the thigh, while it holds on the extending straps, tends to prevent lateral expansion of the thigh muscles, thus removing one cause of displacement of the upper fragment.

7th. In so far as I have used this appliance, it has not appeared to interfere materially with the blood supply to the fragments of the patella.

8th. This appliance leaves the leg free, so that such passive motion can be made as will not interfere with union of the fragments, but will tend to obviate anchylosis at the knee joint.

9th. The degree of extending force in either direction can be increased or diminished according to the requirements of the case.

The following cases have been treated on the plan above described:—

Case 1.—B. K., forty-nine years of age, born in Ireland, a widower, and a laborer, fell from his truck, striking his left knee on a cobble stone pavement. He was admitted to the Long Island College Hospital on the 17th of February, 1880, the day on which he fell. He had a severe and extensive contusion of the knee, with great swelling. The patella was fractured very near the upper end, so that the upper fragment was very small. The distance between the fragments was over an inch, and it was with great difficulty that they could be brought together and kept in place. And I am quite confident that any other appliance that I have ever used would have carried out the indications less perfectly. This patient was kept in bed about eight weeks, when he was permitted to get up and go about on crutches. The fracture was so near the upper end of the patella, that the union was entirely ligamentous. In fact, the small upper fragment appeared to be lost, as it were, in the bond of union; as if a large tendon had united after rupture. There did not seem to be any material elongation of the tendon.

Case 2.—G. B. G., twenty-eight years of age, born in Italy, a sailor, was admitted to the Long Island College Hospital, February 29th, 1880, having a transverse fracture near the middle of the right patella, caused by a fall on the edge of the curb stone. The contusion and the swelling were very great. In a few days the swelling subsided. Then the above described appliance was used to adjust the fragments. The reduction and retention were very perfect. This patient was removed from the hospital on the 17th of March, by some of his friends, thus interrupt-

ing the treatment. The result in this case promised to be very desirable, if the appliance had been kept on.

Case 3.—M. Dunn, thirty-three years of age. born in the United States, single, a laborer, was admitted to the Long Island College Hospital, April 3d, 1880, having a transverse fracture near the middle of the right patella. His foot slipped on a Banana peel, bringing his right knee against the edge of the curbstone. In this case there was great contusion and swelling, followed by inflammation of the joint. It was nearly a week before the appliance could be adjusted; but when the appliance was put on the fragments of the patella were put and kept in place in a very perfect manner. The union in this case was good, and if the bond of union does not elongate after some months, we may *suppose* that it is *bony*.

From all that I can see at present, I think this appliance deserves a further trial: 1st. Because it is not very complex. 2d. Because it can be readily put on the limb. 3d. Because it permits the patient to move about and be comfortable. 4th. And because it has given encouraging results.

Hospital Reports.

BELLEVUE HOSPITAL, N. Y.

CLINIC OF WILLIAM M. POLK, M.D.,

Professor of Obstetrics and the Diseases of Women and Children, in the Medical Department of the University of New York.

Polypus of the Uterus Differentiated from Retroversion.

This patient, gentlemen, is one whom I noticed incidentally in the wards, and who is suffering from some complaint of the pelvic organs which evidently has not attracted much attention from her, as she came into the hospital to be treated for acute articular rheumatism. That having been cured, she complained of some symptoms connected with the back which led to an investigation.

You have just heard the patient tell her own story, gentlemen; she states, in effect, that she is a woman of good, strong constitution; thirty-four years of age; never had any menstrual trouble whatever, with the exception of what we will soon mention; she has had six pregnancies, the last one being a miscarriage at five months, four years ago. She got up from that miscarriage comparatively well, but about a year ago, or a little longer than that, she noticed each time she was unwell that she had pains, as she expressed it, like labor pains, which pains continued until menstruation ceased. After that she was well, without any discharge at all, without any leucorrhœal or bloody discharge, until the next monthly period. During all this time the flow of blood was not abnormal. She was sick only about four or five days each time. She noticed, however, that these labor pains, as she expressed it, came on regularly with each menstruation. Now, at the menstruation before the last she first bled more than usual, continuing twelve days, which was longer than her usual length of time, namely, four or five days. She had a great deal more of this labor pain than at any other time. At her last menstruation she flowed seven days, but there was no pain at all; there were none of those labor pains connected with the discharge. It has only been within the last six weeks that there has been any perceptible leucorrhœa. Before that time, she states distinctly there was no evidence of any special discharge from the vagina. She speaks incidentally of an attack of rheumatism, which I will mention now again, by simply saying she really came into the hospital with acute articular rheumatism, but she was cured of that entirely. In other words, she did not attach much importance to the symptoms which were connected with her pelvic organs, but more importance to the attack of rheumatism; and it has only been since her rheumatism was cured that her attention has been specially directed to the trouble connected with the pelvic organs. She tells us that she suffers no pain now whatever. Now, you see that in a case of this kind coming to us there is not much to take hold of in the rational history.

You have certain pains which would indicate that there is dysmenorrhœa, and a kind of dysmenorrhœa which is probably due, judging from the history, to retained menses. You infer from that that there was probably some obstruction to the flow of blood. Now, had she not borne children you could readily understand that she might have a malposition of the uterus, such as often exists in the unmarried, which would offer obstruction to the menstrual flow; but since she has borne children, the most natural explanation of her dysmenorrhœa which would enter your mind as a practitioner would be that at her last pregnancy and miscarriage the uterus became anteflexed or retroflexed, as a result of subinvolution. The presence of the leucorrhœal discharge here would, of course, suggest a certain amount of endometritis. That is a point which is rather difficult to decide—that is, without an examination—for she is free from pain, or was, at her last menstrual flow. Cases of dysmenorrhœa due to flexures or displacements are not spontaneously relieved, as was the case in this instance.

Now, that being all that is suggested by the history, of course it is necessary for us to make an examination, in order to see whether our suspicions be correct.

As I pass my finger up the vagina, I find it rather voluminous. To begin with, there is an ordinary laceration of the perineum. I feel an elastic mass lying well up in the vagina, and the first impression it gives my finger is that of an epithelioma of the cervix; but when I carry my finger up further I find a ring of tissue surrounding what appears to be a kind of neck in this mass, and passing my finger up further I can slip it up between the cervix, which I take this ring to be, and the mass in question. As I press well up

into what I take to be the canal of the cervix, I find that this extruding mass has a kind of pedicle, a kind of neck, and it seems apparently to be attached to the interior surface of the cervix, although about that I cannot be sure.

Now, here we have a mass protruding from the cervix of the uterus evidently, because that ring of tissue which I felt around the mass can be nothing more than the cervix. It imparts quite a natural sensation to the finger, so that it cannot be the seat of any degeneration. Now, this mass may be one of two things; it is either a polypus or a fibroid.

Is it possible for it to be the uterus? "I think it is possible." What would be the state of the uterus which would give rise to the condition that we find upon vaginal examination here? "Involution." Yes; an inverted uterus is what you meant to say. Involution, you know, is nothing more than the natural changes which may take place in the body of the uterus after parturition; but an inverted uterus might present very much the characteristics that we find existing here. Inversion of the uterus is a condition which is liable to take place at the time of labor. Ordinarily it does not take place unless labor occurs at term. It rarely occurs as a result of miscarriage, particularly at five months. Now, this woman stated that her last pregnancy resulted in a miscarriage at five months. Still, it is possible for inversion of the uterus to occur even then, as a result of gravitation. If it be a polypus, a kind of vermicular action takes place in the body of the uterus, the tumor is gradually forced down toward the cervix, and finally protrudes from the cervix of the uterus.

After a uterus has been inverted for a time, if you carry your finger up into the vagina you will feel a hardened, rounded mass, very much like that which I feel here, that hardness being very much like that which you feel in epithelioma of the cervix. In this protruded portion there is no depression corresponding to the cervix. It is simply a round, smooth mass; but if you carry your finger up alongside this protruding mass you will find that the cervix is grasping the mass.

Now, you see the examination made by the finger introduced into the vagina would not enable you to make the diagnosis between a polypus of the fundus uteri and an inverted uterus. That examination alone is insufficient. But there are other means to which we can resort, which will render the diagnosis quite conclusive. Can you suggest to me what those other means are, which will enable us to make the diagnosis in a case between a possible inversion of the uterus and a polypus? "I think you can tell by the sound." Yes. If it were a case of inverted uterus, the sound, of course, would not pass much beyond the ring that you find surrounding the mass. If it be a case of polypus, the cavity of the uterus is intact; consequently, you would get the ordinary measurement upon the instrument.

Is there any other means for differentiating between inversion of the uterus and a polypus? "By bi-manual manipulation." Yes. When you come to make bi-manual manipulation, for instance, above the pubes, if it were a case of inverted uterus there would be no fundus there; whereas, if it were a polypus the fundus of the uterus would be felt in the ordinary position. Now, although I feel pretty sure that this is a case of simple polypus, yet at the same time, as other better diagnosticians than I have also considered such masses as polypoid growths, and cut them off as they supposed, but, on account of having made a mistake in diagnosis, cut into the cavity of the peritoneum, I think it just as well for us to lose none of the advantages which may be offered by bi-manual manipulation and the introduction of the sound, in order to make sure of a correct diagnosis. In one instance where an inversion of the uterus was mistaken for a polypus, the whole body of the uterus was taken off with the ecraseur.

In the first place, let us see what bi-manual manipulation will enable us to determine. I pass one or two fingers (better two) up the vagina and place them against the mass, so as to steady it and force it up, so that the other hand, when placed on the abdominal wall below the umbilicus, may press against the uterus, or the uterus be caught as it were between the two hands. Now, when I pass my finger into the vagina, I can readily fix the lower portion, the vaginal portion, of the uterus, but unfortunately I have got a very thick abdominal wall. I do not think I am exaggerating, when I say, that it is as thick as my four fingers placed side by side. Now, with an abdominal wall of that kind, although it be relaxed, as it is in this woman, it is not an easy matter to make out the exact condition of the fundus of the uterus. Still, we can get some information by it. Now, pressing well down upon the mass, which is supported, as I said, by the two fingers of the vagina, I believe I am able to appreciate the body of the uterus between the two hands. She complains of a good deal of pain when I press hard, so that I cannot make the investigation as thorough in this way as I would like. Still, in spite of the thickness of the abdominal wall, and in spite of the fact that she cannot bear thorough manipulation, I get evidences which make me believe that I have got the fundus between the two hands. But the question will be settled beyond controversy by the introduction of the sound.

I employ a sound of this kind for the reason that it is quite elastic, and will better follow the irregularities of the surface which are likely to exist in case of polypoid extrusion from the cervix. I may not be able to accomplish it without fixing the uterus with the tenaculum, but I will make an effort in this way first, at any rate, until the tenaculum arrives. Well, I find we are only losing time by endeavoring to do it without the tenaculum, so that the quickest way is just to let her turn on the side; then we can fix the uterus. The uterus moves from my hand when it is carried into the vagina. We can fix it with the tenaculum, and then the sound will go in, probably, without any trouble; that is, supposing it to be a polypus. Now, there is nothing to be seen here. The light is not good enough to show anything. The mass comes within easy reach the moment the speculum is introduced, and then seizing it firmly with the tenaculum, I think I will be able to hold it in position. As a rule, though, the ordinary tenaculum is too delicate to hold these structures as they require to be fixed

in an examination of this sort. The volsella forceps is the better instrument to employ. You notice I just failed. The trouble was, that in passing the instrument, owing to the sharp curve that was necessary, from the contraction of the cervix forcing the growth down, I did not bend the point of the sound enough; consequently it lodged itself in the rugæ of the cervix. But now it has passed all right. You see the measurement of the canal, which, in the absence of any distinct enlargement as found by bi-manual manipulation, would indicate it to be about the proper length. So that our investigation enables us to state that what we have to deal with is a uterine polypus, and not an inversion of the uterus.

Now, as you see, these masses bleed very readily. The slight manipulation that I have just indulged in has been the cause of all the blood which you see here, and some that has trickled away. They are very vascular, and therefore are apt to give rise to much more hemorrhage than this woman has suffered from. In fact, one of the common causes of uterine hemorrhage is just such a growth as you find here. It is a little remarkable, then, that she should have had so little loss of blood. As you see, it is only on two occasions that she had any very great amount of loss of blood.

We can now account for the symptom of which she has complained, namely, the uterine contraction, the uterine pain which she has had at her menstrual epochs, because of the various efforts which have been made from time to time to expel this mass from the uterine cavity, where it originally formed. This mass may form in the cavity of the cervix or in the cavity of the uterus itself. This one evidently has been within the cavity of the uterus. Now, as long as they are small they are apt to excite no more inconvenience than we get from what we understand as ordinary granular condition of the mucous membrane of the uterus. But where they become large, then they become, like any other foreign body, excitors of uterine contraction. Under ordinary circumstances these contractions will take place with great violence at the menstrual epoch, just as you have seen here. The further distention of the uterus, and the engorged condition that it is in, then, at menstruation, seems to set up the contraction that finally ends in expelling the mass. It took about a year, as you see, for this mass to be entirely extruded. I say entirely; that is, the body of the mass is now outside of the uterine cavity, the pedicle being that which remains within. This, then, is the commonest way of ridding the patient of this condition.

Now, the question of treatment is, of course, a very simple one, and that is to remove the mass by means of the ecraseur. The galvanic cautery wire is no doubt the best means of severing the connection, because frequently bleeding is excessive. I remember that once there was a practitioner, and of very wide experience too, who made the statement that it was his rule never to apply even a ligature to these growths in removing them. Most physicians, several years ago, were in the habit of ligating the growth as high up as they could, and then cutting below; but he said his habit was simply to cut them off with the scissors, and the bleeding never amounted to anything. Unfortunately, though, not more than three weeks after he made this statement there was a patient afflicted as this woman is, operated upon in that manner, and came very near bleeding to death; so that it is not safe to rely upon such a means of removing a mass of this kind, as the loss of blood may be excessive. The safest and best plan, therefore, is to remove with the galvanic cautery if it is at hand. If not, draw down the mass and remove with the ecraseur; or ligate and cut off the mass below the ligature. That is what we will undertake to do here, and we would do it now, but that the woman has not yet made up her mind when she will have it done, and, of course, we have to consult the patient regarding that which concerns herself personally.

The case is of special interest, I say, from the fact of a polypus of such a size occasioning little hemorrhage; and then, in addition to that, it is interesting because it enables us to bring out the diagnostic points between inversion of the uterus and polypus of the uterus.

Syphilitic Ulceration of the Rectum, Caused by Sodomy.

Case 2.—Now, the next patient whom I shall show you is quite as interesting as the preceding one; unfortunately, though, she has a condition which is by no means so easily cured, her disease, in fact, being one of the most intractable complaints that we are called upon to deal with. You will rarely see it in private practice as it exists in her. It is only in hospital practice and among the lowest of hospital patients that you find the condition, especially as it exists here. Still, it will afford us an opportunity to draw a comparison between the extreme disease, as we find it, and the lesser forms of it that you are likely to meet with in private practice. I will pass over the case as quickly as possible, as we have not much time.

The patient is a woman thirty-eight years of age, has borne four children, the youngest being eight years old. She complains of diarrhœa, which has continued since last June. She has lost much flesh, and her general health has suffered very much. Her labors were easy.

Now, gentlemen, so far as her statements go, there is nothing in her history which would point to the condition from which she is really suffering. The simple story is, that she was in good health until last June, when she began to suffer with dysentery; and the dysentery has continued from that time until this. A certain amount of emaciation, of course, would come from so long an inflammation of the lower portion of the bowel. Now, it will not do, in cases of prolonged discharge from the bowel, such as this woman has had, to resort to the ordinary treatment that we are in the habit of employing in such cases; that is, simply to constrict the bowel and prescribe a course of diet. In cases of chronic discharge from the lower portion of the bowel it is necessary to make an examination, in order to ascertain the condition there existing, because frequently these discharges are dependent upon ulceration, that, when properly treated, will

result in a cure; but often the ulceration is of a most intractable kind, and do what you will, a cure cannot be effected. We will see, then, just what the condition of the lower bowel is in this case.

Now, the moment that you cast your eye upon the condition which exists about her rectum you see that there is more than enough there to account for all the symptoms of which she complains. In the first place, you find that there is really no sphincter ani muscle. That woman is not relaxing herself at all, and yet when we make traction upon the buttock of the other side, we find that the rectum gapes even more than the vagina. You notice around the borders of the rectum those projections, a number of them. They are hard and painful, and not only so, but you see an ulcerated surface. Now, looking into the rectum, you will see that there is a roughened surface, covered with pus as far the eye can reach, and if you introduce the finger, which I have already done, and do not wish to repeat, you will ascertain that there is a thickened, ulcerated condition of the bowel, quite two and a half if not three inches from the internal sphincter. Now, that is not dysentery, though that is capable, as you see, of giving rise to symptoms such as she has cited; such as belong to ordinary chronic inflammation of the lower bowel, as in chronic dysentery. When we carry our finger into the vagina we find, so far as the uterus is concerned, nothing specially wrong there; but the rectum, as it is pressed upon, feels like a rod, and runs well up beyond the flexure of the peritoneum or Douglas' cul de sac. It is very sensitive. Here is this constant flow of pus, just as you see. In other words it is a case of ulcer of the rectum. Not an ordinary case of ulcer of the rectum, either. You find that you have ulcers of the rectum produced by several conditions. In other words, you may classify them, as those that occur from the retention of hardened fæces, in persons who are broken down by age or other causes. Impacted fæces, then, in the rectum is one cause. In the same way you may have a traumatic ulcer produced by various injuries to the lower bowel, as, for instance, the lodgment of a fish bone. Then, again, you may have it as a result of tubercle; then as syphilis; then as cancer.

Now, in this case we will endeavor, and I think there will be no trouble about it, to settle as to what is the true cause. A rectum with that color, fringed with a hemorrhoidal like mass, but really a condylomatous mass, is of itself almost sufficient to enable us to say that specific disease is at the bottom of the condition in question. Then when we pass our finger into the rectum we find that the sensations imparted are perhaps like those that we would get in cancer of the rectum, malignant disease of the rectum; but the conditions are continuous with the outer surface of the anus. In fact, the ulcerated condition which you see there is identical with that which is found in the whole ulcerated portion of the gut. Now, in cancer of the rectum you will find extensive nodulation, and destruction of tissue lying within the sphincter, but the sphincter itself, and the tissues around it, would not be involved. Then, too, there would be larger growths, larger masses, as a rule, lining the outside of the rectum, in other words, inflammation of the glands, the lymphatics which lie behind the rectum here, the sacral glands; especially if the disease, being cancer, had lasted as long as this patient claims, because it has been nearly a year since she noticed the first symptom. In all likelihood the disease had existed some months before that.

Of course this is not an ordinary ulcer, from injury, because that would present the appearance of a clear cut ulceration lying within the mouth of the sphincter. From tubercles we can make the diagnosis by the fact that her lungs do not contain any tubercles. We have examined them and ascertained that to be true. So we are finally brought back to our original conclusion, that it is syphilitic. Now, when we come to question the woman with regard to that disease, we find that she is the victim of syphilis. She has the marks on other portions of the body, very well shown. I will not take your time to demonstrate them, for we have already done so in one or two other cases at this clinic.

But is the ulceration of the rectum responsible for the condition of that woman's sphincter? I want you to see that there is really no sphincter there at all. I will send the patient out of the room, because I want to tell you why her anus is in the condition in which you see it. Mind you, the woman does not admit it, but there is only one condition that would give rise to a rectum and an anus such as that woman has, and that is sodomy. That vice is responsible for the condition that her rectum and anus are now in. It has been so torn, so distended, that it has lost all contractility; and then, in addition to that, it is thoroughly infiltrated with the syphilitic neoplasm, which you see shown in the condylomata around there, neoplastic growths, so that what little resiliency may have remained after the performance of sodomy has been destroyed by the action of that growth. Now, syphilis is a thing which, apart from sodomy, is not very often directly responsible for stricture of the rectum. A primary syphilitic ulcer in the rectum is one of the rarest of rare things, except as a result of this vice. Chancroidal ulcer of the rectum is more common because a woman with the ordinary chancroid situated in the lower portion of the vagina might very readily have the virus extended to the rectum from the excoriated surface which it presents.

Then, again, there is good reason for believing that tertiary syphilis might be the cause of this condition, because gummy formations will take place in the lower portion of the rectum, and give rise to ulceration, as they will upon mucous surfaces anywhere else. And we believe, though rather difficult to demonstrate, that mucous patches may form in the lower portion of the rectum just as they form about the mouth. But the kind of disease which you see here is that which could only come from the direct introduction of the syphilitic poison, and by that I mean an introduction of the true syphilitic poison into the parts by the vice in question.

Now the question arises, how can we cure her?

I do not think she can be cured. I think there is such an amount of disease there that the best thing to do is to improve her health and perform colotomy, in order to give the parts rest. I believe she will not be cured short of that operation. Of course, the object of colotomy in a case of this sort is to leave the parts at rest. As long as the fæces pass over that portion of the bowel I do not believe it can be cured. But open the bowel at some other point and relieve the diseased part of the irritation of fæces, and there will be a chance for it to heal. But colotomy is a rather serious operation, and we shall first endeavor to relieve her condition by anti-syphilitic remedies, by the most scrupulous cleanliness, and by the local application of mercurials to the tissues. We use here a solution of carbolic acid, simply for the purpose of disinfecting and cleansing, and then we will apply the mercurial ointment, one drachm to the ounce, smeared on by means of a brush throughout the whole of the lower portion of the bowel. At the same time we will put her on the anti-syphilitic treatment, both because she is saturated with the syphilitic poison and because we think the disease here is one that will respond to anti-syphilitic therapeutics. Ordinarily, syphilitic ulceration of the lower portion of the rectum, unless it be due primarily to the true syphilitic poison, is not much affected by the anti-syphilitic treatment. Still, when we find that the disease clearly exists, it is important to put the patients on the anti-syphilitic treatment, because you wish to improve their general tissue tone. A great many cases of ulcer of the rectum occur in syphilitic subjects, not so much as the result of breaking down of tissue as a result of the poison, but rather to the fact that traumatic causes, such as hard fæces, etc., are more likely to act upon the rectum of an individual whose general health is deteriorated by such a poison as this.

With regard to the restoration of her sphincter in case we should be so successful as to cure the ulceration of the lower portion of the gut, nothing, of course, would relieve that but simply taking out a section of tissue upon either side, resecting, as it were, a portion of the sphincter tissue on either side, and then bring the new surfaces together and thus narrow the outlet. That is about the only thing that would be of any special service.

Now, in regard to the constriction; of course, that would be certain to occur here. You can combat it as you would stricture of the rectum under any other circumstances, by the constant use of bougies and dilators.

Editorial Department.

Periscope.

A Case of Complete Transposition of the Viscera of the Thorax and Abdomen.

The following interesting case was reported in the *Medical Record*, September 4th, 1880, by Dr. William Pierson, Jr., of Orange, N. J:—

Mr. G., aged sixty-five; born in New York; married; six feet in height; robust; lumber merchant. Died July 31st, 1880. Early in childhood he observed that the impulse of his heart could be felt on the right side of the chest. It gave him no concern, as he supposed it was the proper place for it.

As he grew older, and learned that the heart was ordinarily on the left side, he consulted physicians in reference to it.

Some supposed it was a congenital transposition; others, that the heart had been pushed over by pleuritic effusion.

Until about a year ago he had enjoyed continuous good health. He was then attacked with dyspnœa, which became more and more serious until the time of his death. He also had anasarca, and his urine contained albumen and casts.

The impulse of his heart was just below the right nipple and about three inches from the centre of the sternum. The valvular sounds were normal. There was an audible bruit over the upper part of the sternum. The interest in the case centres in what was revealed at the autopsy, viz., a complete transposition of the viscera of the thorax and abdomen.

On laying open the abdomen the liver was found on the left side, the lobe to the left being the largest. The proportions of the liver were normal, and the relations to each other of the lobes and fissures were as usual, only they were in inverse order from right to left. The round ligament was to the left of the median line. The gall-bladder bore its usual relation to the liver; but an attack of hepatic colic would have been on the left side. The cardiac end of the stomach was to the right, the pylorus and duodenum to the left. The spleen was found in the right hypochondriac region. The cæcum was in the left iliac fossa, the sigmoid flexure of the colon in the right, and the rectum entered the pelvis from the right.

When the sternum was raised the viscera of the thorax was also found transposed. The apex of the heart pointed to the right side, the left (ordinarily the right) ventricle being anterior. The aorta was given off to the left of the median line, the arch being directed to the right and descending on the right side of the vertebræ. The innominate artery was on the left, and as usual, the first branch; then, in order from left to right, were given off the right common carotid and right subclavian arteries.

The venous side of the heart was toward the left, the venæ cavæ being on the left side and entering the left auricle (normally the right).

The right lung had two lobes, the left lung had three.

The pathological conditions were as follows:—

The kidneys contained numerous cysts, and were smaller than normal, the cortex being very

much contracted. They presented the appearance of the granular kidney.

In the pleural cavities there was a large amount of serum; most of this had probably settled here by gravity since death, as there had been marked anasarca during the last few days. The pericardium contained a quart of blood, with soft, dark clots.

The visceral pericardium around the left pulmonary artery was deeply ecchymosed; this condition extended up the origin of the aorta for one inch and a half. No break could be found in the pericardium to account for the presence of the blood. On section, this ecchymosed condition was seen to correspond to a clot effused between the serous and fibrous layers of the pericardium, the posterior coronary artery passing directly through it. Both coronary arteries were carefully examined, but neither of them presented a source for the hemorrhage, although the posterior was very much enlarged and the seat of atheromatous deposit. The other vessels at the base of the heart were all carefully examined, but none of them presented any rupture by which blood could have escaped.

The aorta was atheromatous and dilated, and its tissue tore like wet paper.

The heart was hypertrophied, particularly the right (the arterial, normally the left) ventricle, with dilatation of its cavity; but the valves were healthy and competent.

The patient presented the pathological conditions usual to Bright's disease.

The clot at the base of the heart was probably due to rupture of small diseased arteries running in the layers of the pericardium, and was probably the source of the blood found in the pericardium. The symptoms noticed in life may easily be accounted for by the disease of the kidneys and the consequent condition of the arterial system. His death, which was sudden, was probably due to syncope.

The following gentlemen were present and assisted at the autopsy: Drs. J. C. Young and Van Wagener, of Newark; Dr. Wilmarth, of East Orange; and Drs. Bayles and Harvey, of Orange.

The Action of Benzoate of Soda in Scarlet Fever and Diphtheria.

Dr. Demme makes the following statement in the yearly report of the Children's Hospital at Bern, published in the *Allgemeine Wiener Medizinische Zeitung*, No. 24. He has treated twenty-seven cases of diphtheria with benzoate of soda internally and externally. Internally, as large a dose as possible was given (five to twenty grams daily, dissolved in one hundred to one hundred and twenty-five grams of water, with the addition of one to one and a half grams of liquorice juice) The external application was made by sprinkling the diphtheritic patches with alcoholic solution of benzoate of soda by means of an ordinary laryngeal insufflator. The applications were repeated every two to four hours.

If the local disease were spreading rapidly and the lymphatic glands of the throat were swollen, Dr. Demme injected benzoate of soda into the retromaxillary and submaxillary regions, and even into the swollen tonsils. Cold wrapping of the body was employed at the same time, for the lowering of the temperature, and cooling baths when there was severe fever. In septic forms of the disease he administered cognac (five to seventy-five grams daily). Of the twenty seven cases which were treated in this manner, six, or twenty-two per cent., died, which must be called very favorable when the severity of the cases is considered. With regard to the special effect of benzoate of soda, Demme arrives at the following conclusions. 1st. Benzoate of soda is an effective antimycotic, both as an internal and an external application. 2d. The application of benzoate of soda, in the form of insufflation on the infected spot, favors the secretion of the mucous membrane and essentially promotes the separation of the diphtheritic deposit. 3d. A reduction of temperature is not produced by benzoate of soda. 4th. In all his cases Demme saw, under the continued use of benzoate of soda, an increase in intensity of the contractions of the heart, generally with diminution of their frequency, and increased discharge of urine. 5th. Benzoate of soda had no effect on nephritis, with regard to the secretion of albumen. The doses which produce a good effect in diphtheria are, according to Demme, the following: for children from three to six months old, two and a half grams daily; from seven to twelve months, five grams; from one to two years, seven and a half grams; from three to seven years, twelve to fifteen grams daily. Demme never observed unpleasant symptoms after such doses.

Syphilitic Disease of the Blood Vessels.

Dr. Karl Huber, of Leipsic, relates the following case in *Virchow's Archiv*, Band 79, Heft. 3, 1880, page 537:—

A woman, aged twenty-two, had enjoyed good health until fourteen years old; when she suffered from scarlatina. In 1876, when she was twenty, she had an attack of left-sided pleurisy. On September 13th, 1878, the patient was admitted into the hospital at Dresden, with syphilitic ulcers of the genitals, psoriasis palmaris, mucous patches in the mouth, and other symptoms. She left the hospital on December 13th, but was again under treatment in January for other syphilitic affections. On both occasions the symptoms disappeared under mercurial inunction. On February 8th, 1879, the patient noticed that her urine was thick, and that her legs were swollen. On February 11th she was admitted into the Leipsic hospital, when there was considerable general œdema, and there were also signs of fluid in the thorax and abdomen. The œdema became slightly less under treatment, but soon returned, and remained more or less until death. The urine was always scanty, pale and turbid, and contained a considerable quantity of albumen, as well as pus-corpuscles, and sometimes casts. Vomiting, diarrhœa and prostration afterward came on, and the patient eventually became comatose, and died on May 19th. The post-mortem examination revealed a general diseased condition of the blood vessels, with widespread calcification, which was most marked in the ar-

teries. The liver was lardaceous and fatty. The spleen, great intestine, mesenteric glands, and right kidney were lardaceous. There were pyelo-nephritis of the left kidney, and inflammation of the ureter; cystitis, ascites and anasarca, with fluid in the thorax and pericardium; embola in the arteries of the lungs; thrombi in the inferior cava and right femoral vein; ulcers of the great intestine and larynx; cheesy deposits, and recent inflammatory infiltrations, with œdema of both lungs. The changes of the vascular system were more extensive in the arteries than in the veins, but all the arteries of the pia mater and brain, and the coronary arteries, were healthy. The other arteries, beginning at the aorta, and extending to the small arteries of the hands and feet, were more or less altered by whitish or yellow patches of thickening, and by calcification, some of the arteries of the extremities being converted into chalky tubes. The lumen of the arteries, in many places, was completely blocked, this blocking being due, in some instances, to the morbid condition of the vessel, in others to thrombosis as well. In the veins there were patches of thickening in the larger branches of the upper and lower extremities, but more in the latter than in the former. The portal veins and several branches of the pulmonary artery were also similarly affected. There was calcification, to a limited extent, in the middle-sized veins, but more extensive in the small veins of the extremities, especially of the lower extremities. Some of the smaller branches of the pulmonary arteries were calcified to a slight extent. In some remarks on the case the author states that the extensive disease of the blood vessels could not have been caused by age, nor were there any grounds for suspecting the influence of chronic alcoholism. In the absence of other causes to account for it, he considers the vascular change must be looked upon as due to syphilis, although differing widely from the changes hitherto regarded as syphilitic. Dr. Huber, however, admits the difficulty of accounting for the escape of the cerebral vessels, even supposing his view to be the correct one.

The External Application of Carbolic Acid in the Treatment of Lupus.

Mr. J. C. Hall sends to the *Medical Press and Circular*, August 25th, 1880, the following report of two cases treated by this agent:—

Case 1.—E. T., sixteen years of age, an unhealthy, anæmic girl, with a family history of phthisis (though none of her immediate relatives died of that disease), was admitted into Monaghan Union Workhouse Hospital on March 4th, 1880. She had suffered from lupus of the nose for two and a half years, which caused partial destruction of the right ala. There were also patches of lupoid ulceration on septum and floor of nasal cavity, gum of upper jaw on right side, and left tonsil. I put her on cod liver oil, syrup of the iodide of iron, and painted the ulcerated parts with pure carbolic acid twice a week. After a few applications the diseased parts of nose began to look better, but the gum and tonsil were very obstinate. However, at the end of two months they yielded to the treatment, and she was discharged cured on May 11th, 1880.

Case 2.—Mrs. D., forty-five years of age, was admitted to the hospital on May 5th, 1880. She is the mother of three children, all of whom are healthy. Her mother died of phthisis. but she herself has always enjoyed good health. The lupus began in her case three years ago, on the tip of her nose. By degrees it spread to both alæ and septum, and involved the entire mucocutaneous surface of nostrils, which, when I saw her, was covered with thick, hard scabs; the external surface of the nose, extending as high as the bridge and to the cheek on either side, was of a dark red color, with here and there patches of a darker red about the size of a small pea, and a few small, round, ulcerated patches. The entire red portion was covered with dry, bran-like scales. The disease in her case was the form known as lupus erythematodes, and caused little or no loss of tissue, although of three years' duration. I gave her four-minim doses of liq. arsencalis three times a day, and had nose poulticed until scabs came off, leaving an ulcerated surface behind, which I painted three times a week with pure carbolic acid, and the red non-ulcerated portion twice a week. After a short time the ulcers began to heal, and the red non-ulcerated surface to assume a pale and healthy appearance. She was discharged cured on May 30th, 1880. I may mention here that the application of carbolic acid caused little or no pain after the first minute. The rapidity of the cure in this case may have been accelerated by the arsenic; but the first case never having had any, shows that the chief remedial agent was carbolic acid.

Intra-Uterine Injection of Tincture of Iodine in the Treatment of Post-Partum Hemorrhage.

Dr. W. E. Foust, of New York, reports, in *The Medical Record*, six cases of post-partum hemorrhage treated by various methods, as the administration of ergot internally and hypodermically; the introduction of the hand into the uterus and removal of the clots, combined with compression of the uterus through the abdominal walls; compression of the abdominal aorta; the application of vinegar to the inner surface of the uterus; the introduction of ice and of the Barnes dilator, filled with ice-water, into the uterus; the injection of hot water; and finally, the intra-uterine injection of tincture of iodine.

He regards each of these methods as of different value in different kinds of cases, but thinks that the injection of tincture of iodine is the most safe and by far the most efficient method we possess for controlling post-partum hemorrhage. The advantages of this treatment, he says, may be briefly stated as follows:—

1st. Iodine controls the hemorrhage, not by coagulating the blood within the uterus, but by exciting the uterus to contract. The blood is expelled in a liquid form, and hence, instead of leaving the uterus filled with a mass of hard, sticky clots, ready to undergo decomposition, the uterus is empty and disinfected.

2d. Tincture of iodine has never, so far as I

can learn, caused any bad result, even when injected into the uterus in full strength. Thus, in Case v, nearly six ounces of tincture of iodine were injected (four of them without dilution), and yet no bad effects followed its use.

3d. The iodine treatment never fails to control the hemorrhage.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

—— We have received from the publishers, Messrs. Doane & Greenough, 116 State Street, Boston, Mass., two large and elegant blank books, one for the register of obstetric cases, the other for clinical urinary examinations, arranged and compiled by J. F. Gould, M.D. We heartily recommend these works to physicians who desire to keep a true record of their cases.

—— Annual announcements for the session of 1880-1881 have been received from the following medical schools:—"Sixtieth Annual Catalogue and Announcement of the Medical College of Ohio;" "Sixth Annual Announcement of the Nashville Medical College, the Medical Department of the University of Tennessee;" "Fifth Annual Announcement of the Medical College of Fort Wayne, Ind.;" "Thirty-eighth Annual Announcement of Rush Medical College, Chicago;" "Michigan College of Medicine, Detroit, Mich.;" "Thirteenth Annual Announcement and Catalogue of the Detroit Medical College;" "Fifty-second Annual Announcement of the State of South Carolina;" "Fifteenth Annual Announcement of the Medical Department of the Willamette University, Portland, Oregon;" "Thirty-first Annual Announcement of the Starling Medical College, Columbus, Ohio;" "Seventh Annual Announcement of the Hospital College of Medicine, the Medical Department of the Central University, Louisville, Ky.;" and "Sixth Annual Announcement of the Medical Department, University of Tennessee."

BOOK NOTICES.

A Treatise on Common Forms of Functional Nervous Diseases, by L. Putzel, M.D., Physician to the Clinic for Nervous Diseases, Bellevue Hospital, Outdoor Department; Visiting Physician for Nervous Diseases, Randall's Island Hospital; Pathologist to the Lunatic Asylum, B. I., etc.; pp. 256.

The Surgery, Surgical Pathology and Surgical Anatomy of the Female Pelvic Organs, in a series of plates taken from nature, with commentaries, notes and cases, by Henry Savage, M.D., Lond., Fellow of the Royal College of Surgeons of England, one of the consulting Medical Officers of the Samaritan Hospital for Women. Third edition, revised and greatly extended. Thirty-two plates and twenty-two engravings, with splended illustrations of the Operations on Vesico-vaginal Fistula, Ovariotomy, and Perineal Operations.

Treatise on Therapeutics, Translated by Dr. F. Lincoln, M.D., from the French of A. Trousseau, Professor of Therapeutics, in the Faculty of Medicine of Paris, etc., and H. Pidoux, Member of the Academy of Medicine, etc. Ninth edition, revised and enlarged, with the assistance of Constantine Paul, Professor Agrégé in the Faculty of Medicine of Paris, etc. Vol. I, pp. 302; vol. II, pp. 299.

The above are the titles of the fifth, sixth, seventh and eighth of the volumes sent us, of Wood's Library of Standard Medical Authors, for 1880, published by Wm. Wood & Co., 27 Great Jones Street, New York.

In the work on "Functional Nervous Diseases" the author treats of such diseases only as manifest themselves through nervous phenomena, but in which so far the search for anatomical changes which are visible to the naked eye or to the microscope has been fruitless. Under this head he classes chorea, epilepsy, neuralgia and peripheral paralysis. In connection with the clinical history of the diseases under consideration numerous cases are recorded, giving the treatment, together with the results obtained.

The title of the next work fully explains its contents. Little need, therefore, be said here, except that the plates, which are admirably executed, comprise illustrations of almost every variety of pathological conditions, together with operations, instruments, etc.; and this volume alone certainly, in a great measure, enhances the value of the whole series.

In the Treatise on Therapeutics, remedial agents are taken up and discussed under their different heads, as: Reconstituents, Astringents, Alteratives, Irritants, Antiphlogistics, Evacuants, Musculo-motor Excitants or Excito-motors, and Narcotics. The remedies are chiefly or almost exclusively considered in their therapeutical relations; their natural history and physiological action being either omitted entirely, or touched upon only slightly. The work shows a large amount of original research, together with a thorough knowledge of the results of the observations of others, to whom, in every instance, full credit is given.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE LATE MEETING OF THE AMERICAN DERMATOLOGICAL ASSOCIATION.

When the project of holding an International Medical Congress in Philadelphia during the Centennial year was first broached by some of the members of the Philadelphia County Medical Society, it was especially urged, in favor of this gathering, that the connections formed at such a representative assembly would not only benefit those privileged to meet with the leaders of thought in the medical world, but that the very association of minds mutually interested in the advance of medical science would give encouragement and fresh impetus to organized study in its several departments. It is a matter of history, that the Congress was a great success; and the medical profession of Philadelphia has particular reason for priding itself upon the results obtained, which, indeed, were beyond anticipation. This success was won only through the arduous and faithful labors of the committee to whom the organization had been entrusted, who certainly deserve great credit for their prudence, foresight and executive ability. We mention this again, because we hold that the earnest and unrequited labors of these gentlemen should not be overlooked nor forgotten.

It was not our purpose, however, to speak of the International Medical Congress itself, further than to show that from the gathering together, upon that occasion, of men interested in special departments of medicine, opportunities arose that were not neglected. Out of the section on Dermatology, for example, grew a national organization, THE AMERICAN DERMATOLOGICAL ASSOCIATION, which, since 1876, has held yearly meetings; and which, composed of a few earnest workers, has contributed very materially to the advance of American Dermatology.

The last meeting of the Association was held at Newport, Rhode Island, August 31st and September 1st and 2d, Dr. L. A. Duhring, of this city, President of the Association, occupying the chair. Several features of the meeting deserve especial mention, as being worthy of imitation by other Associations. In the first place, a printed programme was provided, which was very closely followed, two sessions per diem being held. In the second place, many of the ordinary details of business were transacted in committee, in order to save time. Thirdly, the time of the meeting was spent in the consideration of dermatology, and none was given to entertainments and excursions. Fourthly and finally, the proceedings were conducted with marked earnestness, decorum and dignity.

Resolutions of respect to the memory of Prof. Hebra, who was an honorary member of the Association, were adopted and ordered to be entered upon the minutes. The report of the Committee upon Statistics included details of more than eleven thousand cases, from different parts of the United States, arranged according to districts. Upon motion, the Secretary was instructed to inform the Superintendent of the United States Census Bureau that the statistical information gathered by the committee in reference to the existence of leprosy in the United States was at the disposal of the Bureau.

The officers elected for the ensuing year

were, Dr. J. Nevins Hyde, of Chicago, President; Dr. E. Wigglesworth, of Boston, and Dr. C. Heitzmann, of New York, Vice Presidents; Dr. A. Van Harlingen, of Philadelphia, Secretary; Dr. J. E. Atkinson, of Baltimore, Treasurer.

The next meeting was directed to be held at the same place, on August 30th, 31st and September 1st, 1881. It was decided to publish the papers in the *Archives for Dermatology*, edited by Dr. Buckley, of New York. The meeting was a successful one, and the character of the papers read was uniformly high, and such as to reflect credit upon the Association.

Notes and Comments.

Therapeutical Notes.

OXIDE OF ZINC IN THE TREATMENT OF DIARRHŒA.

M. Cousin recommends, in *le Marseille Médical*, the use of the following formula:—

℞. Zinc. oxide, ℥j
Sodæ bicarb., ℈ ss. M.
Ft. chart. No. iv.

Sig.—One every three hours.

CREASOTE AS A THERAPEUTIC AGENT IN CHEST AFFECTIONS.

Dr. Reuss, of Paris, has, according to the *Glasgow Medical Journal*, employed creasote in the treatment of phthisis with apparent benefit. He prescribes it in lozenges (*dragées*), the formula for each being:—

℞. Pure balsam of tolu, 20 cent. (3 grs.)
Pure beech creasote, 5 cent. (¾ grs.)
Excipient, q.s.

Sig.—Two of these for a dose; given at first night and morning, and gradually increased, sometimes up to ten lozenges in the day.

The Treatment of Pneumonia by Digitalis and Alcohol.

Dr. Albert Joly, in *Le Praticien*, records the results obtained by Dr. Alix at the military hospital of Toulouse, by the use of digitalis and alcohol in the treatment of acute pneumonia. The conclusions are as follows:—

1st. Simple or double free pneumonia is but little serious unless we obstruct its normal evolution and natural tendency to cure by untimely medication. 2d. Its affinity to the eruptive fevers (internal herpes of some authors) seemed to be confirmed by this regular progress. 3d. Pneumonia is essentially a weakening affection, in which the temperature descends below the normal, more than in any other inflammatory disease. It is evident that the principal indication is to combat the debility and raise the organism again by excitants, especially alcohol, which is to some extent a food. Nevertheless, since temperature simply by its elevation often constitutes a danger, it is important to prevent it, not by bleeding, or tartar emetic, but by digitalis, the happy effects of which are undeniable. 4th. Every new cause of increased temperature should be carefully warded off at once, and therefore blistering should not be used, since by the wounds it produces and the accidents it causes it notably raises the temperature. 5th. The exudative pulmonary congestion, which by its abundance creates permanent danger, must be carefully warded off. Hence opium, which favors it, must be cautiously given. Blistering also must be avoided on this account, since by rendering the chest motionless it makes expectoration difficult.

The Action of Salicylic Acid and Salicylate of Soda on the Respiration.

The experiments of Dr. C. Luin, recorded in *la Tribune Médicale*, have shown him that the action of salicylic acid on the respiration is a complete one. Under its influence the respiratory strength undergoes changes according to the period of the observation and the doses of the remedy; diminution with small doses, augmentation with large doses. The carbonic acid undergoes similar modifications, diminution under small and augmentation under larger doses. These changes are unquestionably of central origin, and it is in the respiratory nervous centres that we must seek the most probable explanation of them. MM. Bochefontaine and Chabert showed that one of the properties of salicylic acid was to diminish the reflex actions of the bulbo-medullary gray substance; consequently the substance penetrating the torrent of the circulation would act very promptly on the properties of this substance and thus diminish the respiratory reflex. This will explain the initial slowing and at the same time the diminution of carbonic acid. But under the influence of larger doses the substance accumulating in the cerebro-spinal fluid acts directly on the roots of the pneumogastric, and by this excitation, slight at first, causes an acceleration of the respiratory movements, similar to that produced by feeble excitation of the central ends of the pneumogastrics; but the excitation always increasing after great acceleration, the respiratory

movements soon begin to get slower and slower, and lastly, the excitation reaching its maximum, they stop under the influence of the great excitation of the pneumogastrics; hence the asphyxia which always occurs in animals submitted to experimental doses of salicylic acid. What are the therapeutic conclusions? These experiments show that in small doses salicylic acid is a substance which may really be of service, but one must always mistrust too large doses, which not only cannot be borne by some, but which are in themselves more hurtful than beneficial.

South America as a Health Resort for Consumptives.

Dr. J. Henry Bennet, in a communication to the *British Medical Journal* on the influence of mountain air in the treatment of pulmonary consumption, asserts that the temperature which exerts the most favorable influence in the treatment of phthisis is a day temperature, ranging from 55° to 65° or 70° Fah., and a night temperature between 45° and 50°; in other words, that the climate and temperature which are the most conducive to the physiological well-being of the Caucasian race, are also the most favorable to the treatment of phthisis. He draws attention to the fact that phthisis is rare among the people inhabiting the high plains of Central and South America, although common in the neighboring sea-coast towns. Dr. Comes, with whom Dr. Bennet has lately been in correspondence, states, that during a residence of four years in Quito, where he was one of the professors at the medical school, physician to the hospital, and engaged in active private practice, he only saw two or three cases of spontaneous phthisis among the natives, and in all the cases of imported phthisis from the sea-coast that he met with, the progress of the disease soon appeared to be arrested. He also states, that in a large room, without fire, and with doors and windows open day and night, he found the temperature to oscillate all the year round between 57° and 65° Fah.

Dr. Bennet relates the case of a young married lady, aged 26, whom he attended for two winters at Mentone. She was a native of Guayaquil, but educated and married in France, where she became a consumptive; and finding that her recovery at Mentone was only a partial one, she returned to her native country. She has now been two years at Quito, and has become quite well and robust. But then, at Mentone, she lived shut up, while at Quito, she has lived in the open air constantly. He therefore thinks that the immunity, or comparative immunity, from phthisis enjoyed by the inhabitants of the elevated mountain-plains of tropical and sub-tropical America, from Mexico to the Argentine Republic, cannot be owing to mere elevation—to barometric conditions—inasmuch as phthisis reigns at all elevations, even above 5000 feet, on the mountains of Switzerland. It cannot, either, be attributed to mere dry cold, as the mortality from phthisis is greater in Norway, Sweden and Northern Russia, than in London or Paris. It must, then, be owing to the ideal physiological climate, which enables the entire population to live, as it were, out doors, in the open air, night and day. Why should not the Andes, with a delightfully mild, dry and equable climate, which is unequaled in any part of the world, become *the* health resort of the future?

The Constant Current in Intestinal Occlusion.

Dr. Boudet reports two successful cases in *Le Progrès Médical*. The first patient was suddenly attacked with strangulation of the small intestine, from peritoneal bands or adhesions, shortly after recovery from an acute peritonitis; the recent date of the latter prohibited any attempt at surgical interference. In the second case there was such obstinate obstruction, with intestinal paralysis, from fecal accumulation in the cæcum and sigmoid flexure, that, all ordinary treatment failing, operative measures were contemplated. In both cases the constant current from a Gaiffe's peroxide of manganese battery, of six increased to ten or fourteen cells, was used, the poles being applied either abdominally, or recto-abdominally (the negative attached to a female catheter in the rectum, and three rheophores from the positive pole on the abdomen). The applications, ten in the first and eight in the second case, varied in duration from half an hour to an hour or an hour and a half each, but were not made continuously. Contact was established about every half minute and over; during a second each closure of the current produced a violent intestinal contraction, and the sound placed in the rectum showed well these contractions by its in and out movements; several times the induced instead of the constant current was tried, but it provoked intolerable pain and seemed to act only on the muscles of the parietes. It caused no intestinal contractions or rumblings, or movements of the rectal sound. He uses the induced current only for exciting the muscles of the abdominal walls, whose contractions are often very valuable in aiding those of the intestine. With proper precautions there need be no risk of eschars from the

constant current. A hollow rectal sound is advisable, in order to allow fluid and gaseous matters to escape through it. It is necessary to repeat the application much oftener than is indicated in special treatises, and to prolong them according to the state of the intestine. In one case there was sudden strangulation by peritoneal bands or adhesions, the intestine preserving all its contractility; strong excitations augmented its contractions and detached it from its adhesions. In the other case the electric current gradually restored to the intestine its energy, and after each application it emptied itself partially of its contents, but four days elapsed before obtaining a complete result.

Oil of Eucalyptus.

In the *Deutsche Medicinische Wochenschrift*, No. 30, Dr. Siegen of Deutz narrates some of the results he has obtained from the use of the oil of eucalyptus globulus in antiseptic surgery. He was induced to experiment with it at the suggestion of Professor Binz, and since 1872 has carried on his investigations of its antiseptic properties. He prepares the solution of the oil by dissolving three grams in fifteen grams of alcohol, and diluting with one hundred and fifty grams of water. In this solution he soaks ordinary gauze. This dressing is applied in the wet state, covered with the usual gutta-percha tissue, and the whole kept in position by means of gauze bandages. Thus prepared, the eucalyptus gauze does not appear to irritate or produce eczema upon even sensitive skin, and is perfectly antiseptic.

In one case of a child with caseous glands of the neck Dr. Siegen operated, first dipping the instruments in a two per cent. solution of the oil and washing the surfaces with the same; by scooping out the contents, draining, and applying a wet eucalyptus dressing as above described. Although the spray was not used in this case, the discharges which had penetrated the gauze were quite sweet upon the third day. The slight amount of pus remained odorless, and on the eighth day the cavities had contracted and healed. In a second case, of a child with right genu valgum, he removed a wedge-shaped portion of the tibia, and after fracture of the fibula and proper adjustment of the bone, dressed with eucalyptus gauze, using the thymol spray. The bone wound healed forthwith, and on the tenth day after the operation only a superficial strip of granulations remained.

In a child with purulent inflammation of the elbow joint and fistulous openings, Dr. Siegen performed resection of the joint under the thymol spray, and after washing out the wound with an eight per cent. solution of chloride of zinc, dressed with thymol. The discharges from the wound remained, however, still offensive and profuse, whereupon he changed to eucalyptus dressings, having in the first place washed the surfaces with a one per cent. solution of permanganate of potash. After the first dressing the secretion of offensive pus ceased, and the wound rapidly healed.

His fourth case reported was an abscess of the knee, which was similarly treated, and with equally favorable results.

Dr. Siegen's experience has taught him that a five per cent. solution of oil of eucalyptus may be employed without any drawbacks. Dressings prepared with this solution may be left undisturbed for four or five days, while the two per cent. solution dressings remain aseptic for three days.

Dr. Siegen's researches confirm those of Schulz, published in the *Centralblatt f. Chirurgie*, 1880, No. 4, on the use of oil of eucalyptus in antiseptic surgery.

A Constant Bath Treatment of Fever.

According to the *Lancet*, Sept. 4, 1880, Dr. Reiss, of Berlin, has proposed the employment of the bath in the treatment of typhoid and other febrile diseases, in a somewhat novel form. The antipyretic effect of brief and powerful refrigeration is often transient, and at the height of the disease hourly or half-hourly baths have to be employed. It is proposed, therefore, to employ a continuous but slighter refrigerating agent—namely, to keep the patient constantly in a bath of lukewarm water. A temperature of 88° has been found the most convenient. The use of such baths obviously prevents considerable practical difficulties, which are, however, not insurmountable. The patient should lie in a sheet, suspended, hammock-like, within the bath, and when the first inconveniences are over the patient enjoys it, and can be kept in it for a whole day or several days. Dr. Reiss has tried the method in forty-eight cases of typhoid (besides one incompletely treated case). It was used only in pronounced cases, for the most part in the early stage, the bath being commenced at from the third to the twelfth day. The temperature was taken every one or two hours, in either the rectum or axilla. As a rule, the bath was continued without intermission for the first

twenty-four hours, unless the fall of the temperature was too great. After the second day the rule was followed, to take the patient from the bath whenever the rectal temperature was below 99.2°, and to re-immerse whenever the temperature rose above 101.5° F. The results are said to be strikingly good. With the exception of some very obstinate cases, the temperature fell quickly in the bath so as to reach the normal in from twelve to twenty-four hours. On removal, the temperature rose rapidly in the earlier stages of the disease, more slowly in the later periods, so that the intervals between successive baths were at first short and afterwards gradually lengthened. In obstinate cases, in which the bath at 88° F. did not reduce the temperature below 102°, transient cooler baths were employed to keep the temperature down.

In forty-two cases available for comparison, the duration of the bath-treatment varied between seven and thirty-eight days, and was, on an average, 18.2 days. Of the forty-eight cases, three died, giving a mortality of 6.2 per cent. In two of these there was pneumonia. The latter fact seems to suggest that this method is not free from the danger of occasionally doing harm; but the influence of the bath on the other symptoms of the disease is said to have been not unfavorable. The pulse remains frequent, contrasting with the depressed temperature, but it often improves in quality. The most favorable effect is produced upon the cerebral symptoms, somnolence or delirium rapidly ceasing. Any severe pulmonary or intestinal symptoms were absent in most of the cases.

Correspondence.

The Bromide of Potassium as a Therapeutic Agent.

Ed. Med. and Surg. Reporter:

With the changes of fashion in the different manners of life, come also the different modes of treating disease. New remedies are being constantly added to the list. Some of them possessing merit, others again of very little value. During the last few years no remedy in the pharmacopœia has had a more general use, nor been called to combat a wider set of symptoms than the bromide of potassium. So general indeed has its administration become, that it can be truly called a standard remedy. Throughout the long list of diseases, from the sickness of childbed to the excitement of the various febrile affections, this remedy figures conspicuously; and that it has not failed to establish its virtues, time and experience with it have conclusively proven. What calomel was to the physician a half century back, the bromide is to the practitioner of to-day, It is the one stand-by to which he can fly when in need of a remedy, and yet its virtues are in no wise impaired because of its varied administration. No remedy in use at the present time is more generally prescribed than this. It is a remedy not only known and popular in the profession, but also among the people at large. Frequently, I have people to come to me and say, "I wish you would give me some bromide of potassium; I have a pain in my head; or, I don't feel very well;" or something like that. A short time back I was called to see a man who had fallen in a fit by the road-side. When I arrived at the place, I found the man sitting by a pool of blood, which he said he had vomited, but which I ascertained came from a lacerated tongue. He was evidently just recovering from an epileptic fit. In a few moments he recovered sufficiently to ask me for thirty grains of bromide of potassium, which I gave him. "Now," said he, "I am all right. If I'd had that medicine sooner, I wouldn't have got that fit." He then got up and went on about his business. He evidently knew all about its action, and no doubt had often taken it before. I mention these facts merely to show how well this remedy is known outside of the profession. I could name many more such instances, if necessary. I have under my care, at the present time, an old man who is troubled with a constant pain and buzzing in the head; his only relief is this remedy, which he takes almost constantly in doses of fifteen or twenty grains. Some time back, he sent for me to see him. He said: I must have some more of that medicine; that's great stuff for the head; I don't know what I'd do without it."

That this remedy possesses a great sedative action on brain and nervous centres there can be no doubt, hence, its value in epilepsy, convulsions, neuralgia, the excitement of delirium tremens, etc. Twenty years ago, calomel, ipecac and nitre, were the remedies chiefly relied on in the treatment of fever. To-day, quinine, digitalis and the bromide of potassium, are the sovereign agents, and the results accomplished by the latter are equally as good as the results attained by the former. In the stage of excitement of fever, it is an agent of inestimable value. Combined with digitalis, it offers to the physician a weapon with which he can battle with excited arterial action to great advantage. During the last few months I have treated quite a large number of cases of fever, of a malarial type. Besides giving the quinine, I have prescribed the bromide largely during the height of the fever, with marked benefit in nearly every instance. That it aided very materially in allaying excitement and bringing down the temperature, thereby hastening the cure in these cases, I am well satisfied. In some cases of rheumatism, especially those associated with debility and disturbance of the nervous system, I have found this remedy of great value. In cardialgia and gastralgia, it is also a valuable agent of relief.

Indeed, I know of but few diseases in which this remedy could not be employed at some time with benefit. I think there is no advantage in prescribing such large doses as some recommend. I am sure that I have accomplished as much good by giving it in moderate doses (say, from ten to thirty grains), as I have by giving it in

larger quantities. Some physicians recommend it to be given in drachm doses, repeated at short intervals. The advantage of this appears to me doubtful, besides it is very apt to disorder the stomach, if given in such large amounts. During the first two or three years of my experience with medicine I looked upon this remedy with a good deal of suspicion and doubt. I saw it recommended for so many different affections and diverse conditions that I was led to believe that it was pushed forward, not on account of its merits, but as the result of popular favor. But time and familiarity with it have led me to believe that in it we possess a remedy of no mean virtue; and were I compelled to part with any one of the remedies at my command, I would be very loth to let that one be the bromide of potassium.

OSCAR LEEDOM, M.D.

Plymouth, Pa.

Kava-Kava in Painful Micturition.

ED. MED. AND SURG. REPORTER.

Not having seen any article in the REPORTER on the effects of Kava-Kava in painful micturition, I will, if permitted, report a few cases. About one year ago I commenced to use the fluid extract, rather cautiously at first, but finally prescribing it in all cases, regardless of cause where there was pain, no matter of what character, while voiding urine.

CASE 1.—Charles P., six years of age, had been treated for acute cystitis by an irregular physician until the patient seemed well, with the exception of only a slight smarting or burning sensation while voiding urine. A few days after the doctor had dismissed the case, I was called to see the patient, and found him suffering greatly, being unable to make water without screaming fearfully; fluid extract of kava-kava, dose eight drops in two tablespoonfuls of cold water, to be given every three hours until relieved. The first dose gave some relief, and the second brought perfect ease. The medicine was then to be given only three times a day, same size dose. After four days, there being no further difficulty, the medicine was discontinued.

CASE 2.—George S., fifty years of age, had ague, and on each chill day, commencing with chill and continuing through it, he had great pain in voiding urine. The paroxysm of pain generally continued, though diminishing in severity, up to within a few hours of the commencement of each chill. Doses of twenty-five drops each, until four doses, three hours apart, were given, completely removed all difficulty.

CASE 3.—Mrs. R. B., twenty years of age, pregnant, sixth month, painful micturition, entirely relieved by fifteen drops, three times daily.

CASE 4.—H. S., seventy-eight years of age, had been exposed to cold draughts of air while perspiring freely, was suddenly seized with a chill, followed by fever and inability to make water, only in a very small quantity, attended with severe pain; there was also great tenderness over the region of the bladder. In order to test the virtues of kava-kava still further, I prescribed nothing else. Twenty-five drops in one half tumbler of cold water, two hours apart, removed all difficulty within twelve hours.

CASE 5.—John T., twenty-one years of age, second stage of gonorrhœa; prescribed arg. nit., gr. one-half, aquæ, four ounces, used as injection, and fluid extract kava-kava, twenty drops, three times a day; a cure was effected in six days.

The fluid extract should always be given largely diluted with cold water. I do not think that it is a diuretic, but that it acts directly on the mucous membrane of the bladder and urethra, allaying irritation, and relieving spasmodic contraction of the neck of the bladder.

Polo, Iowa. W. J. HOLMAN, M.D.

Argenti Nitras et Opii.

ED. MED. AND SURG. REPORTER.

Having had quite an extended opportunity of testing the above remedies in all stomach and bowel difficulties for the last six years, and finding them to answer my most sanguine expectations in such troubles as diarrhœa, both acute and chronic, cholera morbus, cholera infantum, and frequently dysentery, when it has resisted other treatment, and believing that this treatment is not generally used and understood by physicians, I feel it my duty to state, through your journal, a few simple facts in regard to the way that I have been in the habit of using them. I have given them to many patients who had gradually sunk under other treatment, until death was the only thing looked for to give relief; and frequently I have seen relief follow the first dose; the bowels coming under control, so that the next evacuation would be of a healthy character; and improvement would be steady until health was restored. My formula is as follows:—

℞.	Argenti nit.,			
	Pulv. opii,	āā	ʒss.	
	Syrup or honey,	q.s.	mass.	M.

Ft. chart., No. xxxv.

For an adult give one as often as the bowels move until relief is obtained; or until the full effect of the opium is produced. If I find indications of a loaded stomach with some undigested substance, I empty it by a good ipecac. emetic, thereby fitting it to receive remedies and nourishment.

In cholera morbus this is the most essential part of the treatment, as nothing usually will be retained on the stomach until we get the depressing effect of some good emetic. In the last mentioned difficulty I frequently use the sulph. morphine, hypodermically, to relieve the intense suffering, until the other remedies can have time to take an effect. Of course it will appear to many that no surprising effect can lie hidden in this formula. But I will leave it to be tried by the profession, and am confident it will find favor.

JOHN BARBER, M.D.

Susquehanna Depot, Pa.

—Professor Klebs has tendered his resignation as Professor in the University of Prague, on account of misunderstanding with his colleagues.

News and Miscellany.

American Academy of Medicine.

The following has been sent us:—

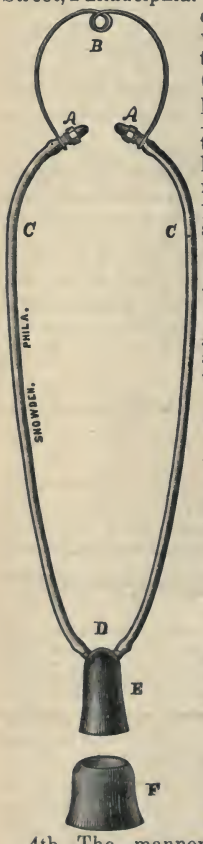
At a recent meeting of the Council, it was resolved to postpone the meeting of the Academy until Tuesday, September 28th.

You are therefore respectfully notified that the Fifth Annual Meeting of the Academy will be held in Manning Hall, Brown University, Providence, Rhode Island, on Tuesday, September 28th, at 4 o'clock P.M.

An address by the President, Dr. Frederick D. Lente, of New York, will be delivered at 8 o'clock P.M.

New Instruments.

The accompanying cut represents a new binaural stethoscope, manufactuerd and for sale by William Snowden, No. 7 South Eleventh Street, Philadelphia. This instrument is composed of a Hard Wood Bell (E), with a Soft Rubber Cup (F), two Flexible Rubber Tubes (C C), attached to the upper portion of the bell by two Perforated Nipples at (D), two Ear Pieces (A A), of hard wood covered with soft rubber pads, the whole completed by a Wire Spring (B), so arranged as to retain the Ear Pieces firmly in position when in use. The advantages claimed for this instrument are its simplicity, together with the perfection and accuracy of its acoustics.



Attention is especially called to the following:

1st The construction of the Bell, the Perforations at (D) being so gauged as to meet accurately at the centre of the Dome of the Bell. By this arrangement the sounds are transmitted with equal clearness to each ear.

2d. The Rubber Tubes are free from all woolen or silk coverings, thus avoiding all friction sounds arising from this source.

3d. The Ear Pieces are covered with Soft Rubber Pads which effectually exclude all extraneous sounds.

4th. The manner of applying the Spring Pressure to the Ear Pieces.

5th. The ready adaptability to all positions of both the patient and physician, in this securing the comfort of both.

A trial of this stethoscope has convinced us that it is the best as well as cheapest binaural stethoscope in the market. Price $3.00.

The Health of Providence, R. I.

Dr. E. M. Snow, of Providence, R. I., mentions in his last monthly report as registrar, that during the first eight months of this year the number of deaths and rate of mortality have generally been larger than the average for the season; but during the last month there has been a considerable falling off in the number of deaths. In the month of August the number was less than the average for the month, and the rate of mortality was not only much less than the average for the month, but even less than the annual average for a series of years in the city.

Cholera in India.

The *Lancet*, September 4th, 1880, informs us that cholera has made its appearance among the troops in several stations in Bengal and the Northwest provinces. In Lucknow, the 13th Hussars and Royal Artillery had several fatal cases in the last week in July. At Moradabad, the 2d Queen's have had a few cases, though of a milder type; while at Allahabad the 2d Batt., 22d Regt., has suffered somewhat more severely, losing ten men and an officer (Dr. Noad) in a few days. In the Punjaub, cholera has also appeared at Peshawur, at Tangi in the Peshawur Valley, and at one or two places in the Khyber.

Personal.

—Dr. C. S. Turnbull has removed to 1702 Chestnut.

—The deaths of two distinguished pharmacologists, Professor Phöbus in Giessen, and Professor Talck in Marburg, have been reported.

QUERIES AND REPLIES.

Dr. A. S. H., of Brownville, Neb.—Your communication has been received, and while we agree fully with you respecting the advertisement you send us, yet we have found, through long experience, that the more publicity you give to quacks the better they thrive.

Dr. J. W. C. O., of Pa.—We do not think it advisable to publish a list of the graduates of Buchanan's College in the Reporter.

Dr. A. S. McK., of Ala.—1. We suggest in the treatment of sciatica the internal administration of turpentine. 2. By addressing Louis V. Helmold, No. 127 South Tenth street, Philadelphia, you will obtain full information with regard to the latest devices in the treatment of varus.

DEATHS.

KILPATRICK.—At Navasota, Texas, on Sunday, 29th Aug., Mrs. Mary M. Kilpatrick, *nee* Tucker, wife of Dr. A. R. Kilpatrick, of congestion of the brain, in the 54th year of her age.

MOYER.—Dr. Jonathan Moyer, a prominent citizen of Lock Haven, died suddenly, last week, of congestion of the brain.

PANSER.—A dispatch from Wadley, Georgia, announces the death of the Rev. Dr. William Panser, a prominent physician and musical author. Deceased was sixty-eight years of age.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1231] PHILADELPHIA, OCTOBER 2, 1880. [Vol. XLIII.—No. 14.

Original Department.

Communications.

CLINICAL STUDIES OF INEBRIETY. PERMANENCE IN CURABILITY.

BY T. D. CROTHERS, M.D.,
Of Watertown, Conn.

An eminent physician who has made insanity and nervous diseases a specialty, has criticised some articles which I have sent to the Reporter, urging the impossibility of permanent cure of inebriety, asserting positively that no cases were ever literally cured, and that no length of time of sobriety was reliable as an indication of permanence in any sense, as the disorder might break out any time, from the slightest causes; the inference which he makes prominent from these premises is that nothing beyond a temporary restoration from the immediate effects of alcohol can follow in any case. This opinion carries on its face its own refutation, and is so entirely unsupported by all clinical evidence that I shall not attempt a formal answer. In many of the cases which I have published the evidence of permanence of recovery was fully equal to that of other diseases upon which elaborate statistics of cure are based. I am confident that inebriety is permanently curable in the same sense that other diseases are; and even now, with all our crude methods, want of means and facilities, it is demonstrated over and over again that, when taken in the early stages, it is one of the most curable of all the organic nerve disorders.

The following case, which has recently ended in death, is presented as a significant illustration of permanent cure, under adverse circumstances, and although but a single case, indicates the possibilities which a larger knowledge and more thorough study of the subject may develop.

John James was born in 1823; his father was an actor, of erratic, impulsive nature, who was alternately a dipsomanic and a genius, bordering on the verge of madness; drinking at long intervals, with great violence, and then reforming and displaying extraordinary energy. Like the elder Booth, his associate actors were always uneasy in his presence on the stage, for the reason that he often became so absorbed in the play as to make it dangerously realistic. He lived a life of extremes, and died suddenly, after a long paroxysm of drink. His wife, the mother of our sketch, was a nervous woman, who died of consumption when the son was three years old. His father died two years after. John James was accordingly taken by a relative, who was also a drinking man. Nothing was noticed during childhood, except his passionate disposition and love for music. At eighteen he entered West Point as a cadet, and graduated four years later with an average rank. He was tall, of light complexion, nervous, impulsive, of ready memory, but lacked concentration of powers.

Soon after graduation he drank to intoxication, for the first time manifesting a remarkable delirium of hilarity and excitement. He was appointed second lieutenant in the artillery, and entered into active service. In the Mexican war he was promoted to a captaincy, for bravery, and in 1850 was changed to the infantry. At this time he drank to intoxication at least once or twice a month, and used beer steadily. When in active service he was forced to keep sober, but when he returned to the fort and could get away he drank to excess. This continued with but little

variation for many years. Most of the time he was on the frontier, and was often forced to abstain. He grew corpulent, was very excitable, and suffered from malaria and rheumatism. He was under treatment at the Hot Springs, in Virginia, for several months. In 1860 he was made colonel of a volunteer regiment, and when assigned an important place in one of the great battles, drank to intoxication, and showed such a reckless daring, exceeding all his orders, that he was suspended. Through some influence he was restored. but at the "Wilderness" he was deliriously intoxicated, and was suspended again. From this time he was put in charge of the ordnance department and manifested great capacity when not drinking. On two occasions he appeared on the battle field without orders, and showed such bravery and dash that his disobedience was overlooked. At the close of the war he was attacked with rheumatism and laid up nearly a year. After recovery he was returned to active duty on the frontier, and was considered a most expert Indian fighter. For the next three years he drank irregularly and very severe at times. His bravery and great skill in Indian tactics prevented him from being discharged. He became so incompetent at last that a long furlough was given him, as preliminary to a final retirement.

In 1868 he was arrested, for drinking, in Boston, and suffered from a severe attack of delirium tremens. A few weeks later he went to Binghamton Asylum, and remained six months. He had delusions, loss of motion and sensation of the lower parts of the body, insomnia, and generel anæmia, and also alcoholic convulsions. He was jaundiced and suffered from gastritis, and, according to the reports of the asylum, was considered a hopeless case. Nothing definite is recorded of his case until he was discharged, six months after, as entirely recovered. Two months later he was assigned to duty in New Mexico, and for three years following was in active service. He was promoted to colonel in the regular army and sent to Oregon.

In 1878 he came east, and visited Binghamton, where I became personally acquainted with him. He appeared then in vigorous health; his face yet bore marks of congestion from alcohol. He had not tasted spirits in any form, from the time he was arrested in Boston. He drank sparingly of tea and coffee; observed great regularity in all his habits of eating and sleeping. He complained at times of unusual depression, which was so intense as to be almost painful. From experience, he knew that alcohol would bring relief, but he had no desire to take it. Often on the march, where water was poor and spirits accessible, a positive aversion filled his mind whenever spirits were offered. When suffering from thirst, he found that roasted coffee beans would bring relief better than any other thing; although often exposed to severe temptations, he had no desire for alcohol in any form; this had grown up in his mind, not so much based on his past experience of its effects, as a positive dislike for both the smell, taste and sight of the fluid. He reasoned at times that it might do good, but the thought of taking it caused a sensation of nausea and weakness of the stomach. The presence of a small quantity of alcohol in his tent would at times produce the same feeling, only less intense. As he grew older the periods of depression lessened and yielded quickly to cold spongings and baths. With the exception of a slight dyspepsia, he was in good health, although he could not endure exposure and excitement as formerly. His mind seemed to me to be very clear and active, although inclined to be impulsive, and enjoy the extremes of action. He was a strong temperance man, and from his own statement, treated the inebriates under him with military discipline. His idea of an inebriate asylum was a half prison a half home, etc. He claimed that he had cured a number of soldiers of inebriety by long confinement and medical means.

Soon after this interview, the colonel returned to active service. I kept up a regular correspondence with him until last December. He was stationed at Omaha then, and wrote me that he was in good health, and working for the cause of temperance every day. He had published some articles showing that inebriety was a disease, and could only be cured by positive means, such as was to be found in the hospitals managed on a military principle. The attacks of depression and neuralgia had diminished, so that they only occurred at long intervals, and followed periods of unusual excitement or exertion. About the 20th of April he was attacked with acute pneumonia. The third day of his illness it was determined to give brandy for the prostration which followed. He made no protest against this treatment, but singularly enough, he was unable to retain it on his stomach, vomiting regularly within ten minutes after it was taken. No attempt at disguising it made any difference, and it was found at last impossible to give him any. In the opinion of the attending physician this was merely a reflex symptom from the intense disgust of the mind, and continued until death;

even when he was in a comatose condition, a few drops of brandy was repelled the moment it reached the stomach. He died after ten days' illness.

This case is interesting in many respects. 1st. The early history indicated a strong hereditary tendency to inebriety, associated with a defective nerve power, which was manifested in his temper and general character when a boy. The association of drinking men, and want of care and training in early life were active favoring causes to develop inebriety. The training at West Point in a measure supplemented his want of training before. But the extremes and irregularities of army life was the most fruitful soil to encourage inebriety. The restraints and forced duty prevented him from going down at once.

2d. When he came under treatment at Binghamton he had been using alcohol to excess for over twenty years, and chronic conditions of disease were very marked. After six months' residence in the asylum he went back into active service, into circumstances attended with great danger of relapse, which continued until death. The special dislike for alcohol was a psychological symptom, which continued until the last, but the nerve defect was apparent in depression and great activity and other peculiarities.

3d. This case was thoroughly cured, and whether exceptional or not, presented a combination of symptoms that gave but little promise for ultimate recovery. The short time of treatment, and the bad surroundings after, the chronic character and hereditary tendency, all were negative factors in the prognosis.

The result of this case points clearly to the possibilities of recovery in other cases less severe, and attended with better conditions. In my opinion, a very large per cent. of all cases of inebriety are curable if they are treated in the proper surroundings and sufficiently long enough to restore the disordered nerve power. This entire subject is yet in its infancy, and all our means and appliances are exceedingly imperfect compared to what they will be in the years to come. The disease of inebriety and its curability cannot be understood by comparative reasoning; and only from a practical study of cases can any clear views be obtained.

—The French Minister of Public Instruction has named Dr. Mathias Duval, Professor agrégé of the Faculty of Medicine of Paris, to the posts of Director of the Laboratory and Professor at the School of Anthropology, vacant by the death of Paul Broca.

REPORT OF CASES.

Read before the Warren County (N.J) Medical Society,

BY E. T. BLACKWELL, M.D.,

Of Hackettstown, N. J.

The Rubber Bandage in Sloughing Wounds.

A. H. O., while engaged about some machinery in motion, received a most extensive injury, embracing the laceration and stripping off of the skin and subcutaneous tissue upon the inner part of the right leg, together with a line of periosteum and the underlying bone, to the depth of a quarter of an inch. When seen, some hours after the accident, the tissues named were shriveled and apparently lifeless; the muscles were completely exposed, as well as much bruised and torn. The treatment consisted in having the wound thoroughly cleansed, and in forcing the contracted and mutilated integument to cover the exposed surface as nearly as possible, not with an expectation of union, but as a protection against external irritation. With this view, adhesive straps were kept applied, until the tendency to contraction was somewhat overcome, and the swelling demanded their removal. On Jan. 10th the limb was dressed, and a lotion of carbolic acid applied. The patient had remained as comfortable as could be expected. A line of demarcation gradually formed, the entire bruised portion sloughing off on the 23d, leaving a very large area of raw surface, covered with granulations. An attempt was made Feb. 2d, by strips of belladonna plaster, to bring the opposite sides nearer together; and on Feb. 9th this was replaced by a bandage of pure rubber, placed directly upon the skin, according to the demonstration of Dr. Henry A. Martin, of Boston, before the American Medical Association in 1877; and to which attention was recently revived by a paper by Dr. Chas. H. Thomas, read before the Philadelphia Medical Society.

The material used is that known by dentists as "rubber dam," and is very soft, very extensible, yet extremely strong. The bandage was of ordinary width, and was applied without reversion. It was removed in the evening, washed and dried, and in the morning was replaced; the result was marvelous. The denuded surface at the time of the application was fully four inches by ten or twelve, and quite deep. Toward the end of March it had filled, by granulation, except the line of fissured bone, the superficial extent of raw surface being reduced to one-third its original boundaries. He had been for some time walking about with the band-

age applied; had even done some work; and was not a little pleased with the achievement of this simple appliance. He removed from under my notice April 1st, and I have not heard of the final result, but cannot doubt its entire success.

The Antiphlogistic Touch in Traumatic Erysipelas.

J. C., laborer, received a severe incised wound of the middle finger of the left hand, from a revolving straw cutter, on March 13th.

He was directed, by an incompetent, to apply vaseline, with the assurance that all would go well. In the course of the second or third day following the adjacent parts became red, swollen, hot, and painful, the inflammation being apparently erysipelatous. Abscesses formed in the palm and upon the back of the hand; the periosteum of the carpal bone of the first phalanx, and the ligaments uniting it to the phalanx below were also destroyed, producing a natural dislocation. This was its condition when I saw it, with Dr. Crane, April 24th.

We amputated the diseased member, April 27th, at the carpo-metacarpal joint, removing the head of the metacarpal bone, cutting down upon and deeply about the bone, and relieving the tissues of a great quantity of unaerated blood, with which they were surcharged. The wound was closed with the interrupted suture.

The engorgement of the adjacent parts continued, notwithstanding the free incisions, interfering with the healing process, and demanding, for relief, "the antiphlogistic touch," or acupuncture with a lancet. This had to be repeated time and time again, the blood sometimes spouting as if from an opened vein. The incision over the joint healed in due time, and was slowly followed by that over the metacarpal bone, the periosteum of which, having been inflamed, adhered to the superficial tissues, presenting, however, a slight cicatrix. The usefulness of the hand appears assured.

Hepatitis, with Severe Colic and Itching.

W. G., aged about fifty years, and quite obese, was taken in September last with partial paralysis of the right lower extremity, followed a month later by colic, believed, from the great pain and tenderness about the epigastrium, as well as the extreme accompanying jaundice, to be cystic, due to chronic hepatitis. The treatment of his attendant having failed of a good result, the patient placed himself in my charge, November 8th. All the tissues open to inspection were intensely jaundiced, and the skin was affected with such severe itching as utterly to prevent sleep or repose. His stomach was irritable; the alvine evacuation dilatory and clay-colored; and the urine was loaded with bile. The liver was very tender in the epigastric region, and appeared to be enlarged. The constipation was overcome, and an attack was made upon the engorgement of the liver by a purge of podophyllin and calomel, repeated for several succeeding days; partial relief from the itching being secured by Indian hemp. On November 12th the cholagogue was superseded by the chloride of ammonium, which has been recently commended in hepatic congestion by several members of the Philadelphia Medical Society, to whose attention it had been called by an East Indian physician, named Stuart. Chloral was added to the hemp, as an anodyne and hypnotic. November 13th, podophyllin and leptandrin were substituted for the purge used at first, to be taken nightly. November 14th, a blister was applied over the affected part of the liver. November 15th, five-drop doses of fluid ext. pilocarpin were exhibited every two hours, producing gentle perspiration and increased comfort. He took, in addition, infusion of buchu and fennel, as also infusion of gentian, with chlorinated soda, and other aids to digestion. The course of recovery was gradual but steady, the violent symptoms being soon ameliorated; the secretions gradually approaching their natural appearance; the strength being reëstablished, and the skin acquiring its natural hue in the beginning of December, when he was discharged.

A NEW THROAT LOZENGE.

BY C. SEILER, M.D.,

Of Philadelphia.

In many of the acute and subacute affections of the upper air passages a combination of chlorate of potash and tincture of iron has long been used with great success in allaying the irritation, by its local effect, and in reducing the inflammation, by its effect upon the general system. Some years ago it occurred to me to institute some experiments with a view to ascertain how much of the result was due to the local and how much to the general effect, or, in other words, whether the patient could be as quickly relieved by mere topical application of the mixture. For this purpose a number of cases of acute and subacute inflammation of the tonsils, pharynx and larynx were treated at the dispensary for diseases of the throat, at the University Hospital, by painting the affected parts with a solution containing tincture ferri chlor. gtt.x, and potass. chlor. gr.x, to

water fl. ℥j, and in cases where the larynx was affected this solution was inhaled by the steam atomizer.

At the same time, an equal number of like cases were given the same mixture internally, in one-half teaspoonful doses three times a day, so as to make the amounts as much alike as possible in both experiments. The practice in the dispensary had heretofore been to direct the patient to gargle with the mixture first and then to swallow it.

The result of these experiments was that the patient felt greatly relieved by the topical applications, but this relief was only temporary, and the case ran its course, as though nothing had been done for it. In those cases in which the mixture had been given internally the course of the disease was shortened considerably, but not as much so as when the medicine was given in the old way, *i.e.*, by gargling and swallowing.

Thus I became satisfied that the medicine acts both locally and upon the general system, and it occurred to me to add to it some bromide of potassium, to enhance the effect. This I did with very markedly good results in the majority of cases. In order to obtain the best effect, the mixture should be given in small doses often repeated, and the gargling should be long continued. There are, however, a large number of patients who cannot gargle, and thus they lose the benefit of the local application, which, as has been shown, is of great advantage. To overcome this difficulty I conceived the idea of combining the different ingredients of the mixture in a lozenge, which, by being slowly dissolved in the mouth, would act locally for a longer time than the mixture, even when used as a gargle.

Considerable difficulty was at first experienced in obtaining a mass sufficiently solid to be formed into lozenges which would contain the requisite amount of chlorate of potash, iron and bromide of potash, but finally Mr. J. F. Hayes, of this city, succeeded in making a very satisfactory preparation, which I have been using for over a year, with excellent results. Most patients prefer the compound chlorate of potash lozenge (the name adopted for the new lozenge) to the mixture, on account of the greater convenience of taking it; especially those whose disease is not sufficiently aggravated to confine them to the house, as is the case with dispensary patients. I am also inclined to believe that the prolonged local action of the drugs thus given alleviate the dryness and pain much more rapidly and effectually than is the case when the patient only gargles with the mixture.

Hospital Reports.

JEFFERSON MEDICAL COLLEGE HOSPITAL.

CLINIC OF W. W. VAN VALZAH, M.D.,

Physician to the Hospital.

REPORTED BY CHARLES R. CRANDALL, M.D.

Case I.—Pyrosis.

Gentlemen, this young woman's name is Mary B., aged thirty years. She is a weaver by occupation, and has been ailing for some time.

You have doubtless noticed that I invariably inquire into the occupation. I do so for the reason that long devotion to particular kinds of employment predispose a person to certain diseases. Hence the miner, the grain thrasher and the workers in lead or minerals are predisposed to certain forms of disease. In this instance the occupation does not bear particularly on the disease from which she suffers.

This woman complains to me of weakness and a general tired feeling. She informs me, too, that she has suffered from vomiting, more or less, for a year. The vomiting usually comes on during the night time, and the matter vomited seems to be mostly water. There does not appear to be any vomiting after meals, and therefore we cannot say it is associated with the digestion of her food. She rather corrects this statement, however, and says that once in a while she vomits after taking food. The matter vomited first comes as water, but in some instances is followed by a whitish mucus. She also suffers, to some degree, from headache; her bowels are habitually constipated. I inquire as to her menstruation, and she replies that she is sick regularly every month, but the amount is scanty. She also has some pain in her back and a slight leucorrhœal discharge. As near as I can learn the headache is not associated with the monthly sickness, nor are the uterine functions sufficiently disturbed to cause the gastric trouble of which she complains. She confesses to being nervous, which is shown by trembling of the limbs and a disposition to cry easily. Associated with all this physical suffering is mental worriment, due to domestic trouble.

We will now examine her for ourselves and see what her symptoms present. Looking at her you observe that she has a tired, anxious countenance, strikingly suggestive of overwork and worry. The tongue is coated, enlarged, and has a tendency to tremble. Her taste, she says, is bitter, and especially so when she vomits.

I now palpate over the stomach, but find no tenderness. Examining the chest I find all of the pulmonary sounds normal. Placing my ear over the heart I ascertain that that organ, too, is normal in its action.

Now, you have all heard the history and seen the patient. Has any one an opinion to offer? Some one replies "indigestion." That is right, to some extent, but what is more pronounced than the dyspepsia or indigestion? Well, we have here a case of pyrosis or "water brash."

The vomiting is not associated with the taking

of food, but has in it a strong hysterical or nervous element.

By pyrosis is understood a peculiar form of vomiting, or regurgitation of a large amount of liquid from the stomach. There has always been much doubt about the true nature of the vomited matter. Some authorities believe it to be an accumulation of saliva in the stomach. Others, that it is simply the juices of the stomach which have collected during the night. Still others have claimed that it is pancreatic juice; but this view is not worthy of credence.

But the question which most concerns us now, is, "what shall we do for this woman?" In the first place we must assure her that she is not in a dangerous condition, inasmuch as persons suffering from this disease invariably get well. If we can thus convince her, the tendency will be to afford a more cheerful and hopeful state of mind, greatly to her advantage. Besides endeavoring to set her mind at rest, let us urge the importance of her giving up work for a time, until she gets stronger. Patients like her, who are worn out, from work and domestic worriment, must have both physical and mental recreation.

Now, in order to control the vomiting, I shall suggest the following combination of useful remedies:—

℞.	Bismuthi subnit.,	gr. x
	Cerii oxalat.,	gr. ij
	Hydrargyri chloridi mitis,	gr. $\frac{1}{12}$
	Pulv. sacchari,	gr. v.

Sig.—One powder to be taken four times daily.

As her tongue is somewhat coated and her digestion a little at fault, I will also order ten drops of dilute nitro-muriatic acid in a wineglass of water after each meal. To relieve the constipation from which she suffers there is no simpler or better remedy than what is called the compound liquorice powder. Its ingredients are sulphur, senna, fennel seed and sugar. She may take a teaspoonful in half a glass of water, before breakfast, every other morning. In regard to her diet, it is evident that she needs a generous amount of easily digested food. I shall advise her to take two quarts of milk daily, a steak and an egg for breakfast, and an egg with her supper. If she is fond of fruit, she can indulge in oranges before breakfast.

Note.—One week later the patient returned to the clinic, much improved; had vomited only twice, and then in the daytime; no vomiting in the night, as previously. Same treatment continued.

Case II.—Acute Tonsillitis.

This man's name is B. R., thirty years of age, his business is that of a waiter. He first called our attention to his condition one week ago, when he complained of pain in his throat. A week previous he had become overheated, and, as he said, had caught a cold, which settled on his lungs and in his throat. On his admission to the hospital his throat was properly examined, and it was found that the tonsils were greatly inflamed and enlarged. The follicles of the tonsils were very prominent, and were pouring out an abundance of mucous secretion. As an interesting feature of the case, associated with the swelling of the tonsils was marked œdema of the adjacent structures. The parts referred to were red, hot, engorged, and would pit under pressure. The uvula or soft palate was so much enlarged that I scarcely exaggerate when I compare it to the size of my thumb.

There were also marked constitutional symptoms, such as high fever, accelerated pulse, headache, great heat about the throat and neck, dyspnœa and constipation. The act of swallowing was very much interfered with, and articulation was indistinct and painful.

The opening between the half arches of the fauces was almost entirely closed; which, of course, gave rise to some of the symptoms mentioned.

Cases thus well marked and urgent are rather uncommon in private practice, but when they do appear, are of a nature to prove exceedingly annoying to a young practitioner. They are cases which require prompt recognition and treatment, owing to the great danger of extension and involvement of important structures. If, for instance, the disease extends forward it may involve the parotid glands. On the other hand, if it extends into the larynx it may give rise to œdema of the glottis. In addition to these dangers there is the possibility of suppuration of one or both tonsils, unless the inflammation is promptly controlled.

After recognizing the symptoms thus hurriedly presented to you, the case was diagnosed to be acute tonsillitis, and the treatment resorted to was substantially as follows:—

The first thing we did was to freely puncture and scarify the tonsils and soft palate, thereby favoring free depletion. This gave immediate and marked relief, as was indicated by the improvement in the patient's talking, breathing and swallowing. I cannot too earnestly impress upon you the value of free scarification in cases of this kind. It is a simple procedure which at once relieves the dangerous congestion and inflammation, and affords the patient decided comfort. All that is necessary to be done is to take a sharp-pointed instrument, like a tenotome or bistoury, and puncture the parts or make a few superficial incisions. Having depleted the parts thoroughly, we then made free use of ice, both internally and externally.

It is always proper in this class of cases to insure cathartic action of the bowels, and for that purpose we gave the patient three grains of pil. hydrargyri and one-half grain of resin of podophyllin. After waiting the requisite time and no movement resulting, we gave, in addition, a wineglass full of citrate of magnesia every hour, until a pint of the solution had been taken. Both of these remedies failing to give the decided action which was necessary, rectal injections of turpentine, soap and water, were employed, after which purgation was established. A gargle was then ordered for the throat, composed of a saturated solution of chlorate of potash, two drachms of tincture of myrrh, in four ounces of infusion of cinchona. Of this he was to gargle at first every hour, but as the symptoms subsided, every second or third hour. After the acute symptoms had largely disappeared, the patient was placed on a

tonic, consisting of twelve drops of the tincture of iron every four hours; to-day he is able to come before you, and is greatly improved. As you have seen, he can walk about and talk distinctly. Examining the throat again, I am enabled to assure you that both the palate and tonsils have almost regained their natural size.

Let us study the next two cases for a moment, comparatively, and then separately. Both are diseases of the chest, but each differ greatly from the other. As the patients now remove their clothing you observe that one has a hollow, flattened and contracted chest, while the other has one that is full, if not abnormally rounded. The former is an elderly man, who shows signs of emaciation and chronic disease, while the latter is a young man, vigorous and looking well. On the one hand are the physical signs of a wasted, broken-down lung; on the other, the signs of an over-distended and hypertrophied lung. We will now direct our attention to the personal history of each.

Case 3.—Pneumonic Phthisis.

John Mc., is a weaver by trade, and a native of this city. His parents were healthy, and died at rather an advanced age, of some lung disease, which he thinks was bronchitis. One sister has also died, but he is not certain as to the cause of her death. Two other sisters are still living.

In 1864 this man was residing at Annapolis, where he took a hard cold, which gave rise to a severe cough. It would seem from his story that the cough never entirely left him, and that it has been especially troublesome every winter since.

In the year 1871 he had an attack of pneumonia in the right lung, and was unable to work for eight weeks. Since that time he has had a troublesome cough, worse at times than ordinarily, but, on the whole, quite persistent. Occasionally, when the cough was unusually violent, the sputa would be streaked with blood, but there has never been pronounced hemorrhage.

Furthermore, he informs me that the cough is always worse in the winter, and that it gives rise to profuse expectoration. He says, that at first the sputa is white, and then it looks like soap bubbles. Doubtless the matter is white, stringy mucus, containing a large amount of air. This is substantially all the history I have been able to glean. When we come now to the physical signs, we find some of them so marked that we are able to study them together.

On inspection, you notice that the chest is thin and flat. There are deep hollows both above and below the clavicle. The general bony structure of the thorax is conspicuous, owing to the decided emaciation. The respiration is feeble and shallow. The left side rises distinctly, while the right side hardly moves. So much for inspection.

Now, I will percuss anteriorly. Resonance is evident on both sides of the sternum, but, if anything, the pitch is highest on the right side. It should be so naturally, but not so pronounced as it is here. Posteriorly, there is marked dullness on the right side over the whole of the lung, and the pitch is decidedly higher than on the left. As I percuss again on the left side posteriorly, those sitting near will observe that the resonance is normal.

Resorting now to auscultation, I learn that anteriorly on the left side, respiration is normal in character, save that it is exaggerated. On the right side it is scarcely audible. The respiratory sounds are not changed, only in the degree of intensity. Posteriorly, substantially the same condition exists. In other words, I am scarcely able to hear anything on the right side, while the sounds are normal on the left. Voice auscultation and vocal fremitus are both increased to a marked degree on the right side.

It may have occurred to some that we are dealing with a case of pleurisy with effusion. If that were so, the chest would be full, the intercostal spaces obliterated, and not only would we have elicited a dull note on percussion, but a flat one. Furthermore, voice auscultation and vocal fremitus, instead of being increased, would have been entirely absent.

Again, the history of a winter cough would suggest chronic bronchitis. We are, however, obliged to exclude that disease, because we find that there is extreme dullness on percussion, and a condition confined to one side of the chest.

From the history, as well as from the physical signs thus elicited, it is evident that we are dealing with a case of pneumonic phthisis, in which the breaking down process has been very slow. The very phraseology must convey to your mind an idea of the disease. It is a slow, degenerative change in the lung, following an attack of pneumonia. There exists a state of chronic consolidation, accompanied by many of the signs and symptoms of phthisis. As has been illustrated in this case, there is cough, expectoration, emaciation, feeble respiration, and dullness on percussion. There may or may not be tubercular deposit, and when the disease has *lasted* for some time, and one lung remains healthy, the probabilities are that there is none. Hence, in a case where there is no tubercular deposit and one lung remains healthy, the prognosis is not necessarily unfavorable. The patient, being careful of himself, may live a long time, one lung doing largely the work of both.

Now, if we treat this case, not with a view of curing, but of prolonging life, we can do this man much good. The chief indications are to control the cough and build up the general health. As you all know, the remedies for cough are numerous, but I believe that the best combination in this instance is—

℞. Ammonii iodidi, gr. vj
Spts. chloroformi, gtt. x
Syrupi,
Aquæ, āā fl. ʒj.

Sig.—To be taken three times daily.

If this dose does not control the cough we will add morphia sulph., gr. $\frac{1}{12}$, to each dose.

In regard to the general health, nutrition is the chief reliance. This man must do all he can to get sunshine and fresh air, and live on the best diet he can secure.

Case 4.—Emphysema.

When we were comparing these two cases you saw the marked difference in the con-

tour of the chests. We will now endeavor to ascertain the cause upon which that difference depends.

This young man complains of a cough and difficult breathing. He has had the cough during the last two winters and it has been very constant and violent. His occupation is that of a common laborer, and hence he is exposed to all kinds of weather. There has been more or less suffering from shortness of breath, and especially so during the last two weeks. He has never blown wind instruments, or strained his lungs in any way as far as he knows. My attention is called to the fact that his feet and ankles have been sufficiently swollen to pit under pressure. Such is all of the brief and rather imperfect history.

Adopting again the same methods of examination we employed in the former case, you will observe the marked fullness and roundness of the chest. Although the man has thin pectoral muscles, the upper portion of the chest is so full that it seems as if they were highly developed. Instead of there being deep hollows and prominent intercostal spaces, as in the other case, the very opposite condition exists, as is shown by the bulging. The breathing is difficult and the inspirations short, which is one of the characteristics of the disease. This labored action is due to the distention of the air cells, and to a want of elasticity of the structures which expel the air. You will also observe the lateral bulging and roundness of the chest walls. In short, the general outlines afford a typical illustration of what is called the "barrel-shaped chest." Placing my hands, one over each lung, there is a plain up and down movement, as if the whole chest rose and fell as one solid structure with each breath.

To bring out the second characteristic symptom I will percuss. As I do so anteriorly there is distinct tympany on both sides. If anything, it is a little louder on the left side, as we might expect. Indeed, there is hyper-resonance down even below the nipple. Latterly, the resonance is not so clear.

Moving around to the posterior surface, I bring out the same sound, but it is less pronounced than anteriorly. Trusting that I have made clear to you the resonance, which is such a prominent symptom in this disease, I now proceed to auscult. There is feeble breathing all over the lungs. Expiration not heard during natural breathing, especially on the right side. On forced breathing the natural sounds come out plainer. The same condition exists posteriorly, especially on the right side. There are no adventitious sounds like râles at present. There is one more symptom we must not overlook, and that is the dropsical condition of the feet and ankles. In what way can dropsy result from a distention of the air vesicles of the lungs? Manifestly it results from an obstruction of the pulmonary circulation, which, in turn, causes hypertrophy and dilatation of the right side of the heart. From this enfeebled state of the heart ensues venous stasis and dropsy. An examination of the heart reveals the fact that the right side is dilated, as is shown by a very weak impulse and by the cardiac enlargement, which extends downward and to the right.

The diagnosis of this case must be plain to those of you who ever heard of emphysema. It is a disease induced by a persistent distention of the air cells. It may originate from many causes, such as blowing wind instruments, violent lifting or straining, climbing mountains, whooping cough, asthma and chronic bronchitis.

This man gives us the history of a chronic bronchitis of two years' duration, and to it we must assign the emphysema from which he now suffers.

A word more in regard to the nature of the disease. I have already hinted that it is a dilatation or distention of the air cells. This dilatation so overcomes the elasticity of the lungs that the air is not entirely expelled, hence there is a decrease of power for the interchange of oxygen and carbonic acid. Therefore, the residual air being in excess, a sufficient amount of fresh air cannot be admitted, and the patient becomes distressed from difficult breathing. Again, the distention of the air vesicles interferes with the capillary circulation in the lungs, and results in causing a venous stasis, which involves the right side of the heart.

As a physiological sequence of this last condition, it is not uncommon to find emphysematous patients suffering from dropsy of the extremities and a congestion of the neck, face and head. As the lung structure itself is involved we can do but very little with medicine towards effecting a permanent cure. The chief thing to be done is to urge the patient not to over-exert or expose himself to bad weather. Exertion tends to still more impede the circulation and burden the heart, and still more distend the air vesicles. On the other hand, exposure increases the liability to bronchitis, which is the underlying cause of the disease. Rest, then, is of great importance, for it prevents the disease from becoming worse; and it may, in a long time, bring about a cure. The one remedy which does the most good in this disease is iodide of potassium, and therefore I will order five grains three times daily. The patient must continue this agent for a long time, in order to obtain the relief for which he hopes.

Medical Societies.

BRITISH MEDICAL ASSOCIATION—PROCEEDINGS OF SECTIONS.

In accordance with our custom we give abstracts of the more important papers read before the Sections.

Section of Medicine.

The subject of the address in Medicine, by John Buckley Bradbury, M.D., F.R.C.P., was "Modern Scientific Medicine." After some preliminary remarks, he said:—

We can hardly estimate how much modern medicine owes to physics, unless we reflect how helpless the physicians in the present day would be in the study of morbid processes and their results, and in the diagnosis and treatment of disease, without such instruments as the microscope, the thermometer, the ophthalmoscope, the

laryngoscope, the aspirator, and other instruments in daily use. In the hands of skilled investigators these instruments of precision have worked changes in the diagnosis, interpretation, and treatment of disease of which the physician and surgeon of an older generation could never have dreamed.

By the aid of the microscope an advance has been made in the exact diagnosis of so-called idiopathic or progressive pernicious anæmia. This disease, although first described by Addison (probably in the *Medical Gazette* for March, 1849), has only during the last few years been generally recognized—about fifty cases have been recorded by various observers. So far as I can ascertain, Addison made no microscopic examination of the blood in this disease; but in the Guy's Hospital Reports for 1855, Dr. Wilks, who had been testing the blood in reference to the number of white corpuscles, soon after Bennett's and Virchow's discovery of leukæmia, thus alludes to it: "In that class of cases which had specially gained the attention of Dr. Addison, and which he has designated 'idiopathic anæmia,' and where, above all others, it might be presumed that the existence of an excess of colorless globules was possible, no such condition has been found. This observation of Dr. Wilks has been confirmed by all subsequent writers on this disease, and, in addition to this means of diagnosis, other important microscopical changes have been noted in the blood in this disease, which help to differentiate it from chlorosis and other closely allied diseases, such as leukæmia, etc. Messrs. Mackern and Davy, and other observers (especially Drs. Byrom Bramwell, Stephen Mackenzie, and Finny), have noticed in blood drawn from persons with this disease by the prick of a needle, that the red corpuscles do not collect into rouleaux, as in health, but lie separately, or form masses of irregular shape; that these corpuscles are very noticeably reduced in number, are variable in size, of great diversity in form, some being oval, others spindle-shaped, some having a tail-like projection, some are larger than the white corpuscles, others not one-fourth of the normal size. In all the abnormal corpuscles the so-called zooid or yellow substance (hæmoglobin) seems to be collected in one part, leaving the œcoid rest of the corpuscle (stroma) clear and transparent, and this probably gives rise to the apparent nucleation of the corpuscles.

C. M. Sörensen, of Copenhagen, emphasizes the counting of the red corpuscles for the purpose of exact diagnosis, and from observations in eleven cases of this disease, says that the number of red corpuscles counted (according to Malassez's method) is only one-fourth to one-twelfth of the normal number. Dr. Stephen Mackenzie has also made some valuable observations on the reduction of the red corpuscles, in various anæmic states; but in none did he find such a diminution as in this disease.

While upon the subject of the microscopical examination of the blood, I must not fail to mention the ingenious hæmacytometer devised by Dr. Gowers, for estimating the corpuscular richness of any specimen of blood. This instrument has the great advantage of accuracy and simplicity of application in clinical practice, and is an improvement in the latter respect upon the "compte globule" of Malassez, and the hæmatometer of MM. Hayem and Nachet. M. Malassez has also devised an instrument, the hæmachromometer, for estimating the amount of hæmoglobin in blood, which is both accurate scientifically, and most convenient clinically. He has pointed out that blood-corpuscle counting is of little diagnostic or clinical use, unless combined with estimating at the same time the amount of hæmoglobin present.

The diagnosis of idiopathic anæmia by means of the microscope furnishes us, then, with a "general truth" as to the abnormal conditions of the blood-corpuscles, which has been "inferred from facts by successive discoverers;" and thus may serve to illustrate the statement that we have at the present time a true science of medicine, in Whewell's sense of the word.

But the thermometer has done even more than the microscope to place medicine upon a scientific basis, and to refute the statement that "we have even yet no science of medicine." I think it may be said, without exaggeration, that the treatise on "Medical Thermometry" by Professor Wunderlich has, more than any other work, furthered the progress of medicine during the last ten years; for it is only during this period that the thermometer has come into general use in the profession, although the first edition of Wunderlich's book was published at Leipsic, in 1868.

The value of the thermometer in clinical medicine has received a fresh illustration in the most interesting researches of Peter and Vidal, on local temperatures in acute pleurisy, phthisis and some abdominal diseases. M. Peter has found in acute pleurisy, from a long series of investigations: (1) that the parietal temperature outside the pleurisy, is from one-half to two degrees Cent. higher than the average temperature of the patient; (2) that the more rapid the effusion, the quicker the elevation of temperature; (3) that when secretion is not going on, and the level of the fluid remains stationary, the elevation of the parietal temperature decreases, but the temperature is still from one-half to one and a half degrees Cent. higher than the sound side; (4) that pleurisy not only raises the parietal temperature of the diseased side, but also that of the opposite side; but the parietal temperature of the diseased side is always higher than that of the healthy; (5) that, while spontaneous absorption of the effused fluid is going on, parietal temperature drops gradually; (6) that in dry pleurisies, the local excess of the heat is less than when there is effusion, and the return to the normal temperature also occurs more rapidly; and (7) that the absolute elevation of the local temperature on the diseased side, is more considerable than the absolute elevation of the axillary temperature.

M. Peter has also investigated the results of thoracentesis upon the parietal temperature, and has found, when the effusion is not reproduced, that although there is immediately after the puncture a slight rise, which lasts for some hours, nevertheless the parietal temperature afterwards decreases, and continues to do so until the normal figure is reached, unless the

effusion is reproduced, when the local temperature rises again.

Physics have also furnished us with the ophthalmoscope, an instrument which, besides being invaluable in the recognition of diseases of the eye, has of late years assisted us materially in the diagnosis of intracranial tumors, syphilis, chronic Bright's disease, acute tuberculosis, tubercular meningitis, cerebral embolism, locomotor ataxy, and other diseases which need not here be specified.

Our knowledge of the uses of the laryngoscope in clinical medicine to-day is little in advance of what it was ten years ago. Some new facts have, however, been added to our store of knowledge in this department of medicine.

In the field of medicine in which the sphygmograph has been used, the harvest has been more abundant than in the case of the laryngoscope, chiefly owing to the researches of Burdon Sanderson having been elaborated by Galabin, Mahomed and others. In his thesis, read in 1873, for the degree of M.D. in this university, Dr. Galabin, formerly Fellow of Trinity College, corroborated the views of Burdon-Sanderson, George Johnson, and others, on the use of this instrument in estimating the amount of arterial tension, as gauged by the height of the tidal or predicrotic wave of a pulse-tracing; and for the first time pointed out that high arterial tension exists in acute as well as in chronic Bright's disease. High blood pressure gives the earliest indication of the grave series of degenerative changes throughout the body, known as chronic Bright's disease, and may, if neglected, lead to disastrous results both in disease of the arteries and of the heart. High blood-pressure is the cause of all so-called heart disease in old persons; it is very amenable to treatment, and its treatment is imperatively necessary.

The possibility of recognizing Bright's disease in its pre-albuminuric stage by means of the sphygmograph leads me to think that this instrument has a great future before it. When people become wise enough to pay their doctors for keeping them in health by periodically examining them to see if there be any abnormal change taking place in their bodies, the sphygmograph must come into general use in our profession.

The remedies for high arterial tension generally are a reduction in the amount of nitrogenous food, purgatives, diaphoretics, bleeding, etc. A milk diet is of the greatest value in some of these cases, as Dr. George Johnson was the first to point out. I have over and over again relieved this condition of the circulatory system by placing patients in bed and on a milk diet. To show the value of bleeding in this condition I cannot do better than to quote a case recorded by Dr. Alexander Harvey, Emeritus Professor of Materia Medica in the University of Aberdeen, in his work, "First Lines of Therapeutics," of a young lad of eighteen, in whom general anasarca, accompanied by profound coma, occurred rapidly after scarlatina, and yielded at once to general blood-letting; the coma disappearing in ten minutes and the anasarca within twenty-four hours after the vascular tension had been relieved.

As the profession comes more and more to recognize the importance of increased blood-pressure the practice of bleeding must come again more into fashion. The *pulsus magnus, durus et tardus*, which the old practitioners invariably bled, was exactly the pulse of high pressure as we now recognize it. There can be no doubt that in the present day we too much neglect venesection. In cases of apoplexy, with increased vascular tension, bleeding is beneficial; and also in uræmic convulsions, which Mahomed regards as probably due to minute cerebral hemorrhages, produced by increased arterial tension, and not to the circulation of excess of urea or ammonium carbonate in the blood (Frerichs), or to anæmia of the brain caused by spasm of the cerebral arteries (Hughlings Jackson and George Johnson).

Some time ago it was discovered that amyl nitrite and nitro-glycerine have the property of relaxing the arterioles, and of thus temporarily reducing blood pressure. This discovery affords a most beautiful instance of what I do not hesitate to call scientific therapeutics, and affords another example that medicine is advancing to the dignity of a science. The drugs I have mentioned are especially suited to those cases in which the heart fails to overcome the great arterial pressure, as, *e. g.*, angina pectoris, and the angina attacks occurring towards the end of chronic Bright's disease. To Dr. Brunton we are indebted for the discovery of the action of amyl nitrite in angina pectoris. In his "Gulstonian Lectures," delivered in 1877, he cites a remarkable instance of its successful administration.

Nitro-glycerine has been shown by Dr. Murrell to have the same physiological action as amyl nitrite, and may be used in the same cases. Its effects are said to be more gradual and lasting; it may, therefore, be taken regularly three or four times a day, and the arteries thus be kept in a constant state of relaxation.

Another instrument of precision for which we are indebted to physics is the aspirator, which has proved such a great boon to the physician and surgeon in the diagnosis and treatment of various diseases, especially of hydatid disease of the liver.

The stethometer, invented by Dr. Ransome, of Bowdon, is another instrument of precision, of value in the detection of some chest affections. Like the sphygmograph, the stethometer is not for ready application at the bedside, and has consequently not come into general use in the profession. It is capable, however, of rendering important information in some doubtful cases of lung disease. According to Dr. Ransome, it has, in several instances, indicated traces of former lung disease that no physical examination of other kinds could display; hence it is certainly useful in examination for life assurance. Dr. Ransome, in a private note, informs me that he thinks stethometry of chief value in estimating the probable course of cases of phthisis and pleurisy. In the chapter on Prognosis, in his book on "Stethometry," he spoke with diffidence on this point; but he is now much more certain of the value of exact measurements in this regard.

I have found electricity of considerable value in some cases of progressive muscular atrophy and of infantile paralysis; and there can be no doubt of its use in removing chronic facial paralysis from cold, and in some cases, of chronic neuralgia. Faradaism and galvanism are the forms in which electricity is chiefly used in the present day; but statical electricity, produced by the old plate machine, has recently been found superior to these, in certain cases of hysteria recorded by Vigouroux, Dujardin Beaumetz, and Erlenmeyer.

Thus far, I have mainly endeavored to show the advantages which have accrued to practical medicine from the use of instruments of precision, for which we are indebted to the science of physics; and perhaps I ought not to conclude without uttering a word of caution, especially to the younger among us, not to rely too exclusively upon the information derived from the use of these instruments, to which perhaps there is a great temptation. The knowledge with which they supply us is, on account of its accuracy, of the greatest value, and at present the advance in the recognition and treatment of disease is chiefly due to them; but we must not ignore the aids which stood our predecessors in such good stead, the information with which the physiognomy, especially of patients, furnishes us; the estimation of the nervous element in patients, and the other features of disease recognizable by our senses, which I need not here mention, but which are known to every cultivated physician, and which cannot be measured by any instruments. We must still, therefore, be contented *stare super antiquas vias*; cultivating that "tact" upon which our ancestors mainly relied.

Section of Surgery.

The address in Surgery, by Timothy Holmes, M.A., F.R.C.S., Eng., was on "Fergusson and Conservative Surgery—Excision of the Knee and of the Hip."

In speaking of Sir William Fergusson and his relation to the history of the progress of Surgery, he said—

It is not necessary to recall the particulars of the career of one whom most of us knew so well; or to give a catalogue of his works; or of the improvements which he introduced into practice. It will be enough for me to test the effect which his career has had on surgery, by the result (as far as has been ascertained hitherto) of that portion of his teaching of which he was, with reason, the most proud, and which, as I contend, marks a great step in the progress of our art. I mean what Fergusson called Conservative Surgery—the excision of bones and joints. Yet, a few words may be permitted to me to mark my admiration of one from whom I learned so much; and who was, I think, of all departed surgeons since Brodie's death, the only one who had passed the line—so difficult to trace in life, but so surely recognized in after times—which separates eminence from greatness. It was not by depth of learning, by eloquence of language, or by philosophical acumen, that Fergusson attained greatness. In all these qualities he had his superiors. It was rather in zeal for the promotion of the art of healing, in amplitude of resource, in dexterity, and, above all, in enterprise and daring, that he excelled all his contemporaries. The truth of this is well illustrated by the great surgical exploit which I have taken as my theme to-day, viz., the introduction of Conservative Surgery. It is nothing to the point to say that Fergusson did not devise any of the operations of conservative surgery; that Park, of Liverpool, and White, of London, had excised the knee and the hips long before Fergusson's time; and that both operations had been repeated by other surgeons. Those operations were practically disused. They could hardly, indeed, have been expected to come into general use before the introduction of anæsthetics. But what Fergusson insisted on was something much beyond the substitution of one operation in surgery for another. It was the great principle of preserving a limb, and, as far as possible, the functions of the limb, while eradicating the disease of one of the joints—a principle as applicable to excisions as to amputations, and which, in the hands of later surgeons, will, I have no doubt, limit the use of many of the excisions as much as, when applied by him, it limited the use of amputation. For there is a vitality in all sound principles which not only outlasts the occasion that called them forth, but often renders the first form in which they appear speedily antiquated, and even apparently erroneous.

I am not sure that it will not be so with excisions in the lower limb; nor would it detract in the least degree from Fergusson's merit, in my mind, if it were so; nay, I think it would enhance it. What Fergusson contended for, and what many of his contemporaries were slow to admit, was, that the surgeon should propose to himself not merely the cure of the disease, which often is easily within the reach of the amputating-knife, but also, as much as possible, the restoration of the limb to its natural functions. That is common sense, you will say, and no discovery. To this I would reply, that almost all great innovations in practice are really expressible in terms of the simplest common sense, and may be made to look like truisms; yet, in the days of which I am speaking, if I may trust my own recollection and a moderately extensive acquaintance with the surgical literature of the period, the principle of conservative surgery was anything but admitted. I can remember being present, thirty years ago, at the first excision of the knee which Fergusson performed at King's College Hospital; and I recollect the sort of half-anxious interest with which the novel proceeding was looked forward to, and the sort of half-disappointment when it was found that the operation was nothing so striking after all—that it was simple, easy, bloodless, and quite within the reach of any one who chose to repeat it. In those days, who thought of laying open the cavity of a large joint—except, perhaps, as a desperate measure in cases of acute suppuration, in which amputation would have been extremely hazardous? Who ever thought of treating diseased joints by incision and drainage, or any of the milder forms of treatment which are now coming into common use? All this is now changed, I admit, as far as the surgery of the knee is con-

cerned, and is perhaps in process of change in the case of the hip; but I am far from persuaded that it is so when smaller parts are in question. I have seen many and many a foot amputated, that I not only think, but (if such a term be applicable to a future event) *know*, might have been saved by some excision or partial removal of the tarsus. Yet, if Fergusson's great principle, that two legs are better than one, be good in the case of the knee, surely the same principle, that ten toes are better than five, may be accepted in the case of the ankle or the tarsus. And the further application of the very same view of surgery is more and more coming into prominence—viz., that by judicious surgical interference, more and more cases may be rescued from all mutilation whatever, and the limb be really "conserved," unshortened, and in some cases even unstiffened, to bear its owner possibly through some future Peninsular campaign, "to go anywhere and do anything."

[*To be continued.*]

Editorial Department.

Periscope.

Removal of the Tongue by Median Division or Splitting.

Mr. Morrant Baker, of London, recommends a method of removing the tongue for disease, which seems to possess some advantages. The operation is thus described in the *Lancet*, April 10, 1880: "After the introduction of a suitable gag, and the removal of any sharp or jagged teeth which might be in the way of the operator, two threads are passed through the tongue about an inch behind the tip, and half an inch on each side of the middle line. The tongue being now drawn forward and upward the frænum, and, as far as it may seem necessary, some of the muscular attachments of the tongue to the lower jaw in front, are now snipped through with strong, rather curved, scissors, and the scissors are then run along the floor of the mouth at the side, beneath the mucous membrane, as far back as may seem requisite, keeping close to the lower jaw, both for the avoidance of hemorrhage and for the sake of being clear of the disease. The operator now, with his forefinger, clears the tongue in front and at the sides, and drawing it well forward again, and giving one thread to his assistant while he holds the other himself, he cuts steadily along the middle line of the tongue from the tip backward, and furthest along the mucous membrane. On the withdrawal of the knife, the finger is again introduced, and it will be found quite easy to complete with it the median division of the tongue, by a little tearing or splitting between the two halves. The only part which cannot be thus torn is the mucous membrane of the dorsum. Hence the advice just given, to divide this with the knife as far as may seem necessary for getting beyond the level of the disease. The ecraseur is now slipped over the diseased body of the tongue, the assistant turning the screw while the operator keeps the loop as far behind the disease as possible. This is, of course, one of the most important parts of the operation; any want of care at this stage being shown afterward by the narrow margin of healthy tissue, or by none at all, left attached to the diseased mass. The insertion of curved needles behind the disease, in order to ensure the division by the ecraseur of healthy tissue, is often advisable, but, for the reasons previously given, must not be considered a sufficient safeguard in the absence of free separation of the tongue's attachments in front and at the sides."

Mr. Baker finds this method good not only in cases of partial removal of the tongue, but of the whole organ also. The two halves are more completely under control than the tongue as a whole; and by working with two ecraseurs simultaneously no time is lost.

Poisoning by Ergot.

The following report by Dr. Jno. M. Keating, of Philadelphia, of a case of poisoning by ergot, appeared in the *Medical Record*, September 18th, 1880:—

I was engaged to attend Mrs. D., in her confinement, to come off the first week in the current month, as it eventually did.

The family had moved to the city from a country town, some years ago, and Mrs. D. was placed under my care for uterine disease. She had some inflammatory trouble following a previous labor. After a short course of the usual treatment she entirely recovered, and soon after became a second time pregnant.

At the third month she over-fatigued herself by some house-cleaning duties, and a miscarriage resulted. I was absent from the city at the time, and upon my return, at the end of the summer, found my patient relapsed into her former state, with side-ache, purulent uterine discharge, subinvolution and its accompaniments. Once more she regained her normal condition, and again became pregnant. As the uterus enlarged there were evidences of "binding down," probably from some old adhesions about the left ovarian region. For some weeks previous to confinement she was unable to leave the house, for the abdomen was very much enlarged. There was great flatulence, and the patient suffered continually from left sciatica. The child was a large one, but the pelvis was capacious.

Fearing some difficulty from uterine inertia, I explained her case to a medical friend, and urged her to send at once for him, should the messenger find me absent from my office. As is usual in these cases, the child came at an inop-

portune time, but my friend arrived early enough to save the patient considerable pain by the application of the short forceps of Simpson. The head had well descended, and was resting at the outlet, but the uterus was unable to contract sufficiently to produce expulsion.

There were placental adhesions of great firmness, and in consequence more than the ordinary amount of hemorrhage.

At last the uterus was well emptied, the binder applied, and two drachms of the fluid extract of ergot administered; this by the doctor himself.

The patient was left comfortable, with instructions to the nurse to send for the doctor at once in case of hemorrhage, and while the messenger was absent to give the patient half a drachm of the ergot every half hour till the doctor's return. By a misunderstanding the half drachm of ergot was administered every half hour from the time the doctor left. I reached the house a few moments after the messenger had been sent in search of me, and found my patient presenting an appearance that was indeed alarming. The face was of a bluish tint, and she seemed in great pain. The pupils were dilated, the pulse was quick, very weak, and occasionally irregular: there was dyspnœa, nausea (no vomiting), buzzing in the ears, and at times a tendency to syncope. The skin was cool and clammy. I was informed that another baby was expected. Upon inquiry, I learned that in all she had taken about half an ounce of the fluid extract of ergot (and this was afterward corroborated by the medical attendant, from the amount left in the bottle, which he himself had brought to the house). I loosened the binder, lowered her head, gave her some whisky, and stimulated the circulation by rubbing, and in the space of half an hour the severity of the symptoms had gradually passed, and patient was left to sleep off a dose of morphia and potass. bromide that was administered.

One of the most interesting features in the case was the powerful uterine contractions. This alone was so marked as to have silenced in my own mind any doubt as to the efficiency of ergot, had I ever been a skeptic on the subject.

The Cause of Milk Sickness.

Dr. M. H. Carson, of Smithland, Ky., says, in a communication to the *Medical Herald* for September, 1880—

In my youth I resided in Blount County, East Tennessee. There was a range of hills through that and Monroe counties. The soil was red and very productive of grain, and where it was not cultivated vegetation was most excellent summer range for the cattle. In many places the milk-sickness prevailed and large numbers of cattle died. At times it proved very fatal to those who used the milk from infected cows. It was discovered that cattle kept penned until dew dried off escaped the disease. This led the people to believe that it was caused from mineral poison that arose out of the earth and settled with the dew on vegetation, as nitre does on the tobacco leaf. In wet weather the stock would not be affected with the disease. This belief became so universal that the owners of stock kept it up until the dew was gone. The region where it prevailed—in Monroe County, in a portion of those hills—seemed to be most thoroughly impregnated. The people living along the valley concluded to fence against it. They built a fence of rails to the distance of six or seven miles. I was not a physician at that time, but my recollection is that those poisoned by using the milk were affected similarly to those poisoned by arsenic. I have attended but one case of milk-sickness, and that was in the neighborhood of Mayfield, Ky., about thirty-nine years ago. My patient was the mother of six or seven children. I treated her as I would a case of arsenical poisoning, and her recovery was complete. From my recollection of those that I have seen in my youth I was satisfied hers was of the same character. In the yard where my patient lived there were two calves sick with the disease. When standing their legs would tremble, and, in fact, the whole frame would be in a quiver. From what I have heard and seen I am fully satisfied that it is a poison similar to arsenic, and that it rises from the earth with the moisture and settles on vegetation.

A Case of Complete Absence of Anus.

Dr. H. Holmes reports the following case in the Boston *Medical and Surgical Journal*, September 16th, 1880:—

August 4th, 1880, Mrs. R. gave birth to a boy, her fourth child, weighing eight pounds. The infant seemed vigorous, and cried lustily. The parents are both healthy and strong, as are their previous children.

Before my visit the following day the superannuated nurse had discovered the child had no anus. There was a complete absence. With the assistance of a neighboring physician and ether, the child was operated upon when forty-eight hours old, with the following result. The raphe of the scrotum extended past the site of the anus to the coccyx, but no *impulse* could be obtained by taxis where the anal orifice should be, nor could the meconium be seen, showing the septum to be something more than a membrane.

An incision at the site of the anus, along the central line, an inch or more in extent, was made by careful dissection through a mass of fibro-cellular tissue, penetrating the pelvic cavity nearly an inch and a half before meconium was reached. The incision was carried back well toward the sacrum, to avoid wounding the bladder, which I endeavored to empty before commencing the operation, and this afforded a point of especial interest. The gentle pressure made over this viscus forced from the penis no urine, but *meconium;* the pressure was repeated, with a like result, furnishing enough of the discharge to leave no doubt as to its character. It would be interesting to know just how or where this secretion found its way into the urethra, but no autopsy could be obtained. This complication, together with the depth of the incision, discouraged any attempt to drag down the mucous membrane of the bowel (as suggested by Amussat)

to the anal orifice, and confine it there by sutures.

The nurse was an octogenarian, and was not persistent in her efforts to nourish the child, and the parents were impressed that the more nourishment it took the longer it would suffer; and it died on the eighth day from its birth and the fifth from the operation.

Paracentesis of the Pericardium.

Dr. Kummell, of Berlin, relates, in *Berliner Klinische Wochenschrift*, 23, 1880, and *Med. Rec.*, July, 1880, the history of two cases in which this operation was performed. In the first a young man was suffering from acute rheumatism, with considerable pericardial effusion. The dyspnœa was extreme, and in order to relieve this symptom paracentesis of the sac was decided upon. The needle of an aspirator was passed in at the fourth intercostal space, and about two ounces of blood-stained fluid were removed. The dyspnœa ceased almost immediately, there was no recurrence of the effusion, and the patient recovered rapidly. In the second case the patient was aged fifty, very anæmic, and emaciated. There was effusion into the left pleura and into the pericardium. On the sixth day of treatment the pericardium was aspirated, and thirteen and a half ounces of clear fluid were removed. The relief was immense, but in two days it was found necessary to repeat the operation. Fifteen ounces were removed, but the patient died on the fourth day, the fluid having rapidly reaccumulated. At the post-mortem examination thirty ounces of fluid were found in the sac. The wounds made by the needle had healed, and no trace of inflammation could be found in the course of that instrument. Kummell recommends that a preliminary puncture should be made with a Pravaz syringe, which can be done without danger. The puncture should be made about two inches from the left margin of the sternum, in one of the spaces between the cartilages of the fourth and seventh ribs. The puncture is best made with a hollow needle, of the diameter of about one-twelfth of an inch.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A monograph on "Interpretations of the Structure and Function of the Kidney," by Andrew W. Smyth, M.D., of New Orleans, La., comes to us in the form of a reprint from the New Orleans *Medical and Surgical Journal*, May, 1880.

——*Godey's Lady's Book* for October has a frontispiece, entitled, "Take your arm away directly, Mr. Joseph, or I'll call Miggs;" "Robin Adair" (song and music); the latest fashions; and much interesting reading matter.

——The contents of the *North American Review* for October are: "The Democratic Party judged by its History," by Emery A. Storrs; "The Success of the Electric Light," by Thomas A. Edison; "The Ruins of Central America," Part II, by Desiré Charnay; "The Observance of the Sabbath," by Rev. Dr. Leonard Bacon; "The Campaign of 1862," by Judge D. Thew Wright; "The Taxation of Church Property," by Rev. Dr. A. W. Pitzer; "Recent Progress in Astronomy," by Prof. E. S. Holden.

BOOK NOTICES.

Transactions of the Medical Association of the State of Missouri, at its twenty-third annual session, held at Carthage, Mo., May 18th, 19th and 20th, 1880. St. Louis, Davis & Freegard, Printers, 417 North Third Street. pp. 164.

Transactions of the Medical Association of Georgia. Twenty-first annual session, Augusta, April 21st, 22d and 23d, 1880. Atlanta, Georgia, James P. Harrison & Co., Printers and Publishers. pp. 251.

Transactions of the State Medical Society of Arkansas, at its fifth annual session. Little Rock: Printed by James Mitchell, State Printer, 1880. pp. 120.

Transactions of the Mississippi State Medical Association, at the thirteenth annual session, held at Vicksburg, April 7th, 8th, and 9th, 1880, with the Roll of Members and Reports on Medical Topics. Published by the Association, Jackson, Miss. The Comet Book Printing Establishment. pp. 177.

Transactions of the Iowa State Medical Society for the years 1879 and 1880. Published by the society; Vol. IV. Des Moines, Iowa State Register Print. pp. 251.

In the Transactions of the Medical Association of the State of Missouri we find, besides the annual address of the President, Dr. G. M. B. Mangles, of St. Louis, on *Medical Ultraisms*, in which he points out the effects of fashions in Medicine, essays on the following subjects:—

"Deformity at the Wrist Joint Successfully Relieved," by Dr. A. J. Steele, of St. Louis; "The Simplest Uterine Manipulations and Operations and the Accompanying Dangers," by Dr. Geo. J. Engelmann, "of St. Louis; "The Relation of Mind to Matter," by Dr. J. M. Allen, of Liberty; "The Dry Method of Treatment of Discharges from the Ear," by Dr. Charles A. Todd, of St. Louis; "On Miasmata," by Dr. J. E. Tefft, of Springfield; "Lithotomy and Lithotrity," by Dr. H. A. Mudd,

of St. Louis; "Report of Committee on Medical Education," by Dr. Samuel S. Laws, of Columbia; "Report on the Progress of Medicine," by Dr. J. S. B. Alleyne, of St. Louis. An animated discussion followed the reading of these papers. A list of the members of the Association, together with a list of officers and places of meeting from the time of its organization to the present, as well as the By-Laws and Code of Ethics, are appended. The volume is bound strongly, in cloth.

The President of the Georgia Medical Association, Dr. Joseph A. Eve, of Augusta, in his address, gave a brief review of the progress which has been made in the science of medicine during the last half century. This was followed by the annual oration, delivered by Dr. W. S. Kendrick, of Atlanta, and a large number of papers of interest, among which were: "Scrofulous Disease of Joints Complicating Phthisis," by Dr. Robert Battey, of Rome; "A Report of Forty-two Cases of Uncomplicated Stricture of the Urethra," and some remarks upon the treatment, also "Two Cases of Aneurism," and one of "Fracture of the Skull in a Child, with Recovery," by Dr. W. S. Armstrong, of Atlanta;" "Organic Affinity—Vital Selection," by Dr. Lewis D. Ford, of Augusta; "Ophthalmic Operations, with Remarks on After-treatment, and the Ophthalmic Use of Quinine and its Therapeutic Action," by Dr. A. Sibley Campbell, of Augusta, with several others.

The Transactions of the Medical Society of Arkansas show that there is a great amount of life and activity in that body. The President, Dr. E. T. Dale, in his address, urged strongly the necessity for medical legislation, a higher standard of medical education, and the establishment of a State Board of Health. The "Report on State Medicine," by Dr. D. A. Linthicum, chairman of committee, showed evidence of earnest determination to accomplish something. Dr. J. B. Cummings gave an account of the yellow fever as it appeared in Forest City, Ark., during the summer of 1879. Dr. J. H. Southall read a paper on "Expert Testimony without Compensation." Besides these, there were several other very interesting papers.

The President of the Mississippi State Medical Association, Dr. E. P. Sale, of Aberdeen, took for his subject "The Duties we Owe our Women," which he discussed from a medical, or rather hygienic standpoint. Dr. B. F. Ward, of Winona, delivered the annual oration, on "Medicine in the Cotton States." Dr. S. V. D. Hill, of Macon, read a paper on "Recent Advances in Surgery," and Dr. N. L. Guise, of Fayette, on "Recent Advances in Obstetrics." Malarial Hæmaturia, was the subject of a paper by Dr. J. M. Greene, of Aberdeen; Dr. F. Kittrell, of Black Hawk, reported a case of "Hemorrhagic Malarial Fever;" and Dr. C. A. Rice, of Vicksburg, read a paper on "Treatment of Wounds." There were several other shorter papers, though of no less importance.

The annual address of Dr. Carpenter, President of the Iowa State Medical Society, was on "Our Duties to the Public." Among the numerous papers presented were: "Mental Peculiarities in Connection with Uterine Diseases," by Dr. M. Abbie Cleaves, of Davenport; "Mental Therapeutics," by Dr. S. B. Chase, of Osage; "Croup," by Dr. William Ott, of Riverside; "Infantile Summer Complaint in its Relation to Meteorology," by Dr. W. W. Grant, of Davenport; "Malaria," by Dr. C. H. Lothrop, of Clinton; "Pyrexia, as an Element of the Typhoid Condition," by Dr. D. Scofield, of Washington; "Asthenopia," (with illustrations of testing for astigmatism), by Dr. E. H. Hazen, of Davenport; "Typhoid Fever," by Dr. Reuben Sears, of Marshalltown; "Clinical Report of a Case of Ovariotomy," by Dr. G. R. Skinner, of Cedar Rapids; and numerous others of no mean interest.

A Practical Treatise on Tumors of the Mammary Gland, embracing their Histology, Pathology, Diagnosis and Treatment. By Samuel W. Gross, A.M., M.D., Surgeon to, and Lecturer on Clinical Surgery, in the Jefferson Medical College Hospital, and the Philadelphia Hospital, etc., etc. Illustrated by twenty-nine engravings. New York, D. Appleton and Company, 1, 3 and 5 Bond St. 1880. Cloth, 8vo, pp. 246. Price $2.50.

This work is the result of a careful study of sixty-five cases of cysts, and nine hundred and two cases of neoplasms of the breast, the microscopical structure of which the author has examined, and also investigated their general pathology, and applied the principles which are fairly deducible from their anatomy and history, to their differential diagnosis and to their rational treatment. A treatise based upon the systematic analysis of so large an amount of material cannot fail to recommend itself to the intelligent surgeon, especially as it, so far as we know, is the only recent work published which affords any trustworthy information on this important subject. The author shows an intimate knowledge of the investigations of others, and refers to them frequently throughout the work, a fact which materially adds to its value.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	**$5.00**
Half-Yearly Compendium of Med. Science,	**2.50**
Reporter and Compendium, - - -	**7.00**
Physician's Daily Pocket Record, - -	**1.50**
Reporter and Pocket Record, - - -	**6.25**
Reporter, Comp. and Pocket Record, - -	**8.25**

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE INCREASE OF INEBRIETY.

The subject of the abuse of intoxicating beverages is so trite a one that nothing but the magnitude of the evils it produces could justify so frequent reference to it. But the fact is, the position of medical men towards it is so influential that they more than any other class of the community should endeavor to have positive opinions and be able to state and defend them clearly.

It cannot be doubted but that within the last ten years the general professional opinion has become more and more decidedly against the consumption of such beverages. This is especially noticeable in England. That is a country where the general habit of the better classes has for generations been toward free indulgence, and most physicians a score of years ago expressed themselves in favor of the constant moderate use of beer, wine and spirits. Within the last twenty years the use of these beverages has vastly increased among the lower classes, chiefly through the opening of thousands of ale houses under an act passed in Gladstone's time, and by the permission to all grocers to sell liquor in bottles. The depravation of health and morals has been so clear that a visible change can be seen in the tone of all the principal medical journals. The eyes of the profession are opened to the enormous ill effects of such indulgence, and the opinion is gaining ground daily that some severe restrictive measures will have to be inaugurated.

Such leading sanitarians as Dr. B. W. RICHARDSON and Dr. ALFRED CARPENTER pronounce unhesitatingly in favor of total abstinence as the only safe ground, at least for the Englishman. They believe in dealing with the inebriate in such a manner that he will not harm and ruin, as he generally does, his family with himself. The only way to do this is by declaring him *non compos mentis* and placing him in restraint.

Such a resource will meet with great opposition in England as it will in this country. To be sure we have on the Statute Books of several States laws to this effect; but the difficulty of enforcing them is so great that it is only attempted under exceptional circumstances. To make them useful, it must be recognized that an uncontrollable craving for drink is a kind of insanity, but that an ordinary drunkard is not insane, but only violates an ordinance, for which he should be punished. It will not do to confound these separate classes. The public know too well, that plenty of men who frequently drink to excess are not insane, and it will not do to attempt to pass the same statute with penalties the same for both cases. This is well put in an article by Dr. J. K. BARTON, in the English *Practitioner*. He concludes his discussion of the subject as follows:—

"We may sum up, then, that dipsomania is a real insanity. That if unchecked it will assuredly kill the patient. That the only possible way to cure, or stop it, is to put the patient under restraint for a period not less than twelve months, but if for three years, there is more chance of a permanent recovery. And we would urge most strongly the necessity for the State interfering and legislating on their behalf. Also that we require two distinct acts—an act for the treatment of dipsomaniacs, and an act for habitual drunkards."

Such, no doubt, will be the tendency of future

legislation; and it is felt to be a pressing necessity at just this time.

The organization of institutions for the treatment of this class of cases is receiving increased attention. The lamentable failures which have taken place in some instances, in this country, are justly attributed to erroneous theories of management, or defective executive ability on the part of the superintendents. With increased experience and a more accurate discrimination of cases, we cannot doubt that such institutions will become more numerous and more successful.

Notes and Comments.

Therapeutical Notes.

TREATMENT OF INCONTINENCE OF URINE.

Mr. Roberts Arthur Jones states, in the *British Medical Journal*, September 11th, 1880, that the treatment he has usually adopted, and always found successful, in "Noctural Incontinence of Urine," is sponging with cold water, night and morning, especially the loins, and the following mixture:—

℞.	Tinct. belladonnæ,		℥ ss
	Liquor potassæ,		
	Glycerinæ,	āā	℥ ij
	Aquæ,	q.s. ad	℥ viij. M.

Sig.—Two tablespoonfuls night and morning. (N.B.—This dose, is of course, intended for adults.—Ed).

TREATMENT OF ANAL FISSURE.

Dr. Hamon informs us, in *Le Praticien*, that instead of employing forcible dilatation, he applies to the fissure, with a camel-hair brush, a solution consisting of one part of chloroform to two parts of alcohol. Two or three applications, at intervals of two or three days, usually suffice to effect a cure. The first application is very painful, but each subsequent one becomes less so.

JABORANDI IN MUMPS.

Dr. Testa states, in *Il Morgagni*, that he has employed this remedy in the form of infusion in five cases, and draws from his practice the following conclusions:—

1st. Jaborandi is an efficient remedy in mumps. 2d. The efficacy is explained by its hydragogue, and especially its sialagogue properties. 3d. Administered early it will prevent the development of the affection. 4th. It may prevent the metastases which are not infrequent.

HOW TO DISGUISE THE TASTE OF BROMIDE OF POTASSIUM.

The unpleasant taste of this drug may be easily overcome by giving three drachms of simple syrup with each drachm of the bromide. The three drachms of syrup, if properly made, should contain about one hundred and fifty grains of sugar. This completely alters the taste, giving it an agreeable nutty flavor, not unlike to cocoanut milk, if largely diluted. Children take it with avidity. The sugar in no way alters the medicinal virtues of the drug. This is a boon to epileptics and others who have to persevere in large doses of the bromide.

TREATMENT OF HERPES.

M. A. Fournier, in *La France Médicale*, recommends, after washing the ulcerated vesicles of herpes with hypochlorite of soda solution diluted with half its volume of water, that the wound be covered with cotton wool impregnated with the following powder: subnitrate of bismuth, four parts; calomel and oxide of zinc, of each, one part. If the eruption is extensive, he recommends absolute rest, the administration of baths with bran or starch, and the internal prescription of opium and bromide of potassium.

The Treatment of Gonorrhœa.

Mr. W. Watson Cheyne, Assistant Surgeon to King's College Hospital, gives, in the *British Medical Journal*, July 24th, 1880, the results of a series of experiments in the treatment of gonorrhœa which he has carried out, and which are worthy of being extensively known. It has been demonstrated by Neisser that organisms are present in great abundance in gonorrhœal pus, and Mr. Cheyne has verified the observations by cucumber infusions with some of the discharge. Acting upon the known effects of certain antiseptic materials, he decided to adopt iodoform and oil of eucalyptus. In order to bring them into certain contact with the suppurating surface, he had bougies made of these materials and cacao butter. The formula is—five grains of iodoform, 10 minims of oil of eucalyptus, and 35 grains of cacao butter. The bougie is introduced into the urethra, and a strap and pad over and around the orifice retains the bougie there until it is dissolved. After this, an injection of boracic lotion (saturated aqueous solution of boracic acid) or an emulsion of eucalyptus oil (one ounce of eucalyptus oil, one ounce of gum acacia, water to 40 or 20 ounces), to be used for two or three days. At the end of that time injections of

sulphate of zinc, two grains to the ounce, may be begun. For a day or two the purulent discharge continues, but afterwards it steadily diminishes in amount, becoming in four or five days mucous, and ceasing altogether in a week or ten days.

Treatment of Nævus.

A correspondent to the *British Medical Journal* states that some time ago he tied a mixed nævus, of the size of a bean, upon the shoulder of a female child, eight or nine months old. Four hours afterward he removed both needles and ligature, with the view of preventing a scar—a plan recommended by Mr. Cooper Forster. Much inflammation was caused by exposure to cold; and the nævus, at the end of two months, was unaffected. The operation was repeated (under chloroform, as before); but at the end of eight hours an attempt to remove the thread failed; it therefore remained in its place. It had been tied tightly enough to cause fluid to exude from the tumor. Next day there was inflammation around the base. He now drew the surrounding skin of the back, chest and shoulder toward the tumor, by means of long strips of plaster, so as to throw it into loose folds (thus relieving tension), leaving the tumor visible in the centre. The redness and swelling quickly disappeared; there was not a drop of pus or other fluid seen; the tumor dried up, and in a few days fell off with the ligature; not thrown off by ulceration, but simply falling like a dead leaf. Since ulceration causes a large scar, and as it probably depends chiefly, as in many other cases, upon the tension of the surrounding skin, this expedient may save marks in situations where it is important to avoid them. The scar in this case was not so visible as even a mild vaccination-mark.

New Operation for Prolapsus Uteri.

The *Canada Medical Journal* informs us that a radical operation of a novel character, for the relief of prolapsus uteri, has been originated by Lefort, of Paris. It consists in uniting the anterior and posterior vaginal walls along their mesial lines, so as to make two vaginas instead of one. After the operation the two vaginas lie in lateral proximity, like a double-barreled shotgun. The surfaces freshened are about half an inch wide and two inches long, and are held in position by sutures. The operation is said to be not difficult of performance, and quite successful in preventing prolapse.

The Peripheric Measurements of Temperature.

Dr. B. von Auress, has, according to *Würzburger Phys. Med. Verhandlungen*, Band xiv., measured, in fifty patients with pulmonary disease, the temperature of the skin by means of a specially constructed thermometer with a flat reservoir for mercury, which was protected against the influences of the external temperature by a glass shade. He sums up his result in the following sentences. 1st. The peripheric measurements of the temperature of the skin may be of practical importance. The grades of temperature observed are not accidental, but they are in direct relation to certain conditions of the internal organs (lungs). 2d. In healthy persons, it is only seldom observed that the temperature of one side is equal to that of the other. A slight irregular difference is almost always observed; sometimes the temperature of the right side is higher, sometimes that of the left side, the difference, however, never exceeds 0.1 to 0.3°C. (0.18 to 0.54 Fahr). 3d. The temperature is always higher on the side where there is an inflammatory process. The difference varies from 0.3 to 1.5°C. (0.54 to 2.7 Fahr). The temperature is lower at a point of the skin which corresponds with a cavern situated at the periphery, than at any other parts of the chest. 5th. That portion of the lungs which is completely croupous gives a lower temperature than the part which is in the first stage of pneumonia.

On the Cause and Prevention of Phthisis Pulmonalis.

Dr. Fredrick Eklund, of Stockholm, in a paper read before the Swedish Medical Society, June 18th, 1880, which is now before us in pamphlet form, claims to have found in the sputa of those affected with phthisis small, round lymphoid cells, filled with what he calls phthisis bacteria (micrococcus phthisis dryotemenos). Having further examined samples of earth and decaying animal and vegetable substances taken from districts where phthisis is common, he invariably found micrococci, which were identical with phthisis bacteria, and he concludes from this that phthisis is a disease of miasmatic origin. As a prophylactic against this disease he considers it of the utmost importance to isolate the houses we live in from the ground on which they stand, by means of asphaltum, or cement; to impregnate the floor planking with paraffine or boiled linseed oil, and to remove the damp air from cellars through chambers surrounding the chimney. Regarding phthisis as a contagious

disease, he thinks that the walls of tenement houses should be replastered and papered, and the floors scraped whenever there is a change of tenants, and recommends that every possible sanitary precaution be taken to prevent its spread.

A New Dressing for the Navel.

Dr. Dorhn recommends, in *Centralblatt für Gynæcologie*, No. 14, 1880, the following arrangement, in order to avoid the evil effects which occasionally follow the separation of the cord when dressed in the usual fashion. The newly-born child, after having its navel string tied and cut, is first washed in the usual manner, after which it is laid on a table, and the remains of the navel string, as well as the parts round about the navel, washed with a two and a half per cent. solution of carbolic acid. The cord is now tied a second time, with a ligature which has been duly carbolized, and the superabundant portion of navel string cut off with its previous ligature attached to it. A layer of carbolized wool is applied over the stump of the navel string, and over all a portion of sticking-plaster about the breadth of the hand is firmly fastened. This dressing is allowed to remain till the seventh day without being either aired or renewed. On removing it then, the remains of the navel string will be found either nearly or entirely separated. In the former case it is cut off with a scissors. The author declares that he has found this dressing satisfactory in twenty-eight cases.

Subcutaneous Injection of Water in Articular Rheumatism.

According to *Gazette des Hopiteaux*, August 15, 1880, Prof. Potain exhibited at the Necker Hospital the effects of injecting water in a case of polyarticular rheumatism. First, he injected a solution of morphia (one centigram to fifty grams) opposite one of the knees, which scarcely caused any pain, but gave very little relief, the patient continuing to suffer greatly. Immediately afterward an injection of pure water was made opposite the other knee, which caused excessive pain as it penetrated into the dense tissues surrounding the joint. But in forty-five seconds all pain had ceased, the patient seemed relieved as if by enchantment, performing rapid movements with the limbs that just before he dared not move. The means, of course, has no curative action in rheumatism, and is a mere adjuvant, which, however may often prove of great utility.

Xylotherapy.

The *Medical Press and Circular*, September 8th, 1880, informs us that at a recent meeting of the Société de Therapeutique, M. Dujardin-Beaumetz read for M. Jourdanis a note on the æsthesiogenic properties of certain woods applied to the skin, which he calls xylotherapy. M. Jourdanis has applied plates of wood to the insensible skin, and as with plates of metal, magnets, sinapisms and blisters, has obtained a return of sensibility. The applications of wood seem to be more active than the other means. All woods do not act with equal intensity, and with regard to their efficacy may be classified in the following order: cinchona bark, thuja, rosewood, mahogany, pitch pine, walnut, maple, apple; poplar, ash and plane produce no effect. Return of sensibility is accompanied by congestion of the skin. We cannot suppose these phenomena to be caused by electric currents.

---

of the committee is now in Europe, with instructions to purchase books to the value of $125. The Doctor explained that the Sydenham books contained the most complete and valuable set of plates ever published.

Dr. George D. Hersey read an interesting paper on embolism of the middle cerebral artery. The case illustrated was that of a person paralyzed throughout the entire right side, and presented several unusual phenomena.

form attacks, at intervals of one or of litholA-

All the means employed to cut short these attacks were fruitless. When Dr. Katz saw the patient, at the end of last year, he was not long in discovering at the bottom of the left auditory meatus a black mass, which was extracted with some difficulty, and was found to consist of a roll of cotton wool covered with cerumen. Freed from this foreign body, the woman found herself relieved at the same time of the disagreeable sensations in the left ear, and the convulsive fits.

Treatment of Uterine Fibroids and Myomata.

In a paper read before the French Association, and published in *l'Union Médicale*, August 17th, 1880, Prof. Courty stated that he was able in most of these cases to effect resolution of the tumor by a combined plan of treatment, and in almost all cases to produce real and considerable relief. Besides general measures—tonics, alteratives, iodide and bromide of potassium, etc.—he resorted to (1) injections, used as hot as the patient could bear them (about 113° Fah.), composed of twenty-five grams of carbolic acid to the litre of water, this being an excellent anti-

congestive and anti-hemorrhagic measure; (2) subcutaneous injections of ergotine; and (3) the electrolytic action of the continuous current. Prof. Verneuil observed, that success attended this treatment in about a third of the cases, it being excellent in the congestive form of fibroma, but of no avail whatever in old fibromata. In cases in which serious hemorrhages are met with, and one or two tender points can be felt in the region of the ovaries, hypodermic injections of morphia relieve the pain and arrest the hemorrhage. M. Denucé also stated that he had found these morphia injections very efficacious, and in one case, after employing them three or six months, he obtained complete resolution.

To Get Leeches to Fasten.

Almost every physician has at times experienced the difficulty of getting these animals to bite. The following plan is commended, and will be found effectual in all cases when the leeches

[illegible] exude from the tumor. Next day there was inflammation around the base. He now drew the surrounding skin of the back, chest and shoulder toward the tumor, by means of long strips of plaster, so as to throw it into loose folds (thus relieving tension), leaving the tumor visible in the centre. The redness and swelling quickly disappeared; there was not a drop of pus or other fluid seen.

[illegible] a single leech is to be applied, the same plan is adopted, using a test tube in place of a glass; by this means the animal may be compelled to bite at just the point desired.

Treatment of Diphtheria.

M. Crequy, according to *La France Médicale*, commences his treatment of diphtheria by removing the false membrane with a forceps; he endeavors by a twisting motion to remove the membrane, without breaking it, in as large a piece as possible; he then with a sponge dabs the denuded mucous surface with a solution of tannin. He never hesitates to adopt this method in all cases.

Fracture of the Neck of the Femur.

Dr. Bezzi draws attention, in *Lo Spallanzani*, Nos. 1 and 2, 1880, to a sign which is pathognomonic of fracture of the neck of the femur, but which is not generally known. In examining the space between the trochanter and the crista ilii, it will be found that while, on the sound side, the muscles occupying this region (the tensor vaginæ femoris and the gluteus medius) are tense, and offer to the hand a considerable feeling of resistance, they present on the affected side a deep, well marked depression, a flaccidity and diminution of tension, from displacement upward of their points of insertion.

Correspondence.

Septicæmia from the Use of a Rubber Bandage.

Ed. Med. and Surg. Reporter:—

Martin's Rubber Bandage having been now before the profession of America, if not the world, for some three years, without a murmur from any one, might be construed into a success; and we might suppose that it had taken its place beside the splint, the plaster jacket, or the extension apparatus, and been assigned to a position of universal usefulness. But I am compelled to dissent from the views generally expressed regarding its use, particularly in varicose ulcers of the leg. I have on several occasions observed symptoms which I thought were referable directly to its use, and yet the general high estimate placed upon its use in these affections somewhat deterred me from expressing my belief in the harmfulness of the bandage, until I was forced to accept it as a fact, as the following case will show:—

C. P., aged forty-three; in general good health; has suffered from varicose veins of the right leg for eight years, an ulcer at times appearing and being very hard to heal, on the lateral aspect of the leg, a short distance above the ankle. I applied a good rubber bandage, in the usual way, and the leg began to shrink and the ulcerated place to improve, until suddenly, after the use of the bandage about five days, there were severe pains developed in the leg, extending to the groin, accompanied with inflammation of the lymphatics running from about the ulcer, and also great swelling and redness of the integument, extending entirely around the limb.

The bandage was at once left off, and soothing applications, poultices, etc., applied.

Chills developed, accompanied with high temperature, the peculiar odor of the breath and sweat, and in fact all the appearance of septicæmia. This condition persisted for about a week, when, under the use of sodium salicylate and aconite together with the local use of acidum sulphurosum and glycerine, the symptoms abated, and the patient made a rather slow convalescence. After some two weeks' interval I urged the use of the bandage again, being yet doubtful as to the agency it had in producing the condition, when, after a five days' constant use a repetition of the symptoms occurred, with more extensive adenitis than before. During the use of the bandage it was always removed at night, cleansed thoroughly and applied again in the morning. Every source of poisoning in this case can be excluded, except the bandage itself or the decomposing tissue about the ulcer. From the recurrence of the same train of symptoms after a return to the use of the bandage, and a suspension during the interval, it appears reasonable to refer the trouble

to the use of the bandage; I doubt not that others have had a like experience, but, under the pressure of high authority for the use of the bandage, have refrained from giving expression to their honest opinion.

Finally, although the rubber bandage may prove a great boon to some sufferers, yet I fear it may greatly injure others. Just how to discriminate is what we may learn by experience and free discussion. S. D. POLLOCK, M.D.

Abingdon, Ill., September 15th, 1880.

Resuscitation of an Apparently Still-born Child.

ED. MED. AND SURG. REPORTER:

On the night of the 11th instant I was hurriedly called to attend Mrs. B. in labor. I found she had been in labor but a short time when, to use the expression of an attendant, the foot came down; this occurring about an hour before I arrived at the residence of the lady. After a prolonged effort, the lady being almost unmanageable, and refusing to take chloroform, I brought down the other foot, and drew the fœtus about half away, where it remained for half a dozen or more imperfect pains. Of course, the position of the child cut off completely the circulation through the cord; and feeling that certain death to the child must inevitably result, and that quickly, I made extraordinary efforts to deliver. Failing to hurry the labor, I gave up, and informed the two or three ladies present that I thought we would undoubtedly lose the child. After a, to me, very prolonged delay, expulsive pains of sufficient force set up, and I shortly delivered the child, still-born.

Thinking there was no possibility of resuscitating the child, as there was no perceptible pulsation in the cord, I made no effort in that direction; but sat looking at an apparently dead child, with my hand resting, luckily, directly over the region of the heart. I felt the heart pulsating, but I thought at first it was my own arteries doing duty in my fingers; on a closer examination however, I found it was really the heart of the child. I immediately began artificial respiration, efforts to inflate the lungs, warm baths, etc., and was rewarded, after a very prolonged trial of everything I could think of, by a prolonged, sighing gasp. Thus encouraged, I redoubled my efforts, and I soon had the little fellow breathing regularly. I remained three hours, and left both mother and child doing remarkably well, considering everything.

This case has undoubtedly taught me never to give up a still-born child until I know, of a certainty, it is dead. J. E. STINSON, M.D.

Montague, Texas, Sept. 13th, 1880.

Mutual Aid Association of the Philadelphia County Medical Society.

ED. MED. AND SURG. REPORTER:—

On Thursday, 16th inst., the first social reunion of the Association was held, at the residence of the President, Dr. Benj. Lee, Manheim street, Germantown. In addition to the members of the Society a number of prominent physicians were present by invitation. The gathering, which lasted from four to eight in the evening, spent an exceedingly pleasant time in the spacious grounds (some sixteen acres in extent), the enjoyment being heightened by the delightful concert performed by an orchestra, the illumination of the gardens after dusk, and a bountiful attention to the necessities of the "inner man." The pleasure of the event was enhanced by the sedulous attention shown to his guests by Dr. Lee's accomplished family, who vied with each other in rendering the occasion one long to be remembered, and one which cannot fail to bind in closer ties of friendship the members of this noble Association. W. R. D. B.

Philadelphia, September, 1880.

NEWS AND MISCELLANY.

Rhode Island Medical Society.

At the quarterly meeting of the above Society, held recently, Dr. Timothy Newell, on behalf of the Library Committee, reported that the said committee had received the publications of the Sydenham Medical Society of England, amounting to some eighty volumes; and that a member of the committee is now in Europe, with instructions to purchase books to the value of $125. The Doctor explained that the Sydenham books contained the most complete and valuable set of plates ever published.

Dr. George D. Hersey read an interesting paper on embolism of the middle cerebral artery. The case illustrated was that of a person paralyzed throughout the entire right side, and presented several unusual phenomena.

Dr. E. T. Caswell reported a case of litholapaxy, of considerable interest, in which he had successfully removed from the bladder a stone weighing forty-three grains, by means of the crushing process.

Dr. Carl Ernst, of the Rhode Island Hospital, reported a case of aneurism of the intercostal artery, and another of a wound of the trachea. The latter was that of a woman who had attempted to cut her throat with a razor.

The Board of Censors then submitted a report, recommending the following gentlemen for admission as Fellows of the Society, who were duly elected by ballot: Drs. E. B. Smith, E. P. King, F. P. Capron and George F. Keene, all of Providence.

Dr. E. G. Browning read a paper on neuralgia of the facial nerve, resulting from an ulceration of the canine tooth. The case was successfully treated by the employment of galvanic electricity.

An extended and interesting discussion followed the reading of the paper, in which Drs. F. H. Peckham, G. H. Stanley, J. O. Whitney, A. Ballou and others, took part.

Dr. Wm. F. Hutchinson read a paper on neurasthenia, which was listened to with absorbing interest. The Doctor has a large special practice in this and kindred diseases of the nervous system. He wished to impress his brethren of the value of greater clinical investigation. He presented cases of three varieties of neurasthenia—

cerebral, gastric and genital. There was nothing, in his opinion, equal to a complete change of environment for the patient. As a general thing he excluded bromides and opium in his treatment. Alcohol, however, he had found a *sine qua non*. This he administered usually in the form of light wines.

Dr. S. W. Butler, of Newport, exhibited some specimens of worms ejected from the stomach, and described the circumstances attending each of the cases.

Dr. W. S. Bowen, of East Greenwich, had something to say about inflammation of the retina of the eye; and he was followed by Dr. George W. Porter, with a paper on Battey's operation for the removal of the ovaries. The operation began first to be practiced about 1872, and was looked upon at the time with great distrust by the profession. It was thought that it unsexed the woman. It was shown, however, that there were certain contingencies in which this operation should be resorted to to save life.

Drs. A. E. Tyng, J. H. Eldredge and W. F. Hutchinson made remarks on the use of this operation; and the latter also read letters from Dr. Wm. A. Hammond and other noted practitioners, in which they all coincided in regarding the use of Battey's operation as inexcusable in the majority of cases.

Dr. S. S. Keene followed, with a paper on a certain epidemic of malarial diseases at Drownville.

The several papers were referred to the publication committee, and before the meeting closed, the secretary, Dr. V. O. Hardon, called attention to the recent death of Dr. Wm. B. Greene, of East Greenwich, and appropriate action thereon was taken by the Society.

Sanitary Work in Russia.

A paper published at St. Petersburg, called the *Golos*, says that the order to disinfect districts where diphtheria is rife, by burning sulphur in the houses after closing them hermetically, meets with great opposition in Russia, the peasants regarding it as a profanation. The mortality among the children does not seem to distress the peasantry very much, since a good many are left and more are coming. In many cases the sanitary agent is unable to get into the house, and but for the police, a Sister of Charity engaged in sanitary work would unquestionably have been burned alive at Tedoulki, on a pile prepared for her. In some localities the nuns encourage the peasantry in resisting the sanitary authorities.

Some of the Effects of Medical Legislation.

From the *Medical Register* of the Illinois State Board of Health, for 1880, it appears that the total number of practitioners in the State, when the law regulating the practice of medicine went into effect, July 1st, 1877, was about 7400. Of these only 3600, or less than one-half, were graduates or licentiates, the remaining 3800 being unqualified practitioners. The graduates and licentiates at the present time number 4825, and the non-graduates 1500, or, in other words, the number of qualified practitioners has increased by about 1225, while the number of unqualified practitioners has decreased by 2300, which gives a diminution in the total number of practitioners equal to 1075. The number of itinerants in the State in 1877 was 73; in 1880, only nine. The number of cancer doctors in 1877 was 23; in 1880, only four.

Do we need any more eloquent plea for sound medical legislation? Are there no other States that require a similar purgation?

Personal.

—Dr. R. Stansbury Sutton has declined the professorship of operative surgery in the College of Physicians and Surgeons of Baltimore, which was tendered him, his professional engagements here being such that he could not leave Pittsburg in time for the college session, which begins October 11th, 1880.

—Professor Rizzoli, of Bologna, who died recently, at the age of seventy, made, just previous to his death, a donation of $1,250,000, to the City of Bologna, for the erection and maintenance of an orthopedic hospital.

Fearful Ravages of Smallpox.

Advices from Ottawa, dated September 23d, say, that a gentleman just returned from the desert says that fully one hundred and twenty deaths have occurred from small-pox. In one camp of sixteen persons, all but one boy died. The Tete Boutes Indians are about extinct.

Another Quintuple Birth.

The *Medical Record* tell us that on September 18th Mrs. Hazzard, of Monticello, Ill., is said to have given birth to five children. They were all alive at last accounts.

OBITUARY NOTICE.

—Professor Giovanni Polli, of Milan, died recently, after a long illness. Professor Polli is best, known for his researches upon the subject of fermentation. The value of sulphurous acid, the sulphites, and of boracic acid as anti-fermentatives, was shown by him.

QUERIES AND REPLIES.

Dr. S. H. B., of Texas, requests some one of our readers to give his experience in the treatment of obstinate cases of tinea circinata or tetter. I have used lotions of corrosive sublimate, tincture cantharides, acetic acid, both singly and in combination, and both with and without the internal administration of arsenic and continued through a course of many months. In many cases the eruption will seem to be checked for a while, but will return in spite of the continuation of remedies; and in no case in which there is an involvement of the nails of the hand or foot have I ever succeeded in thoroughly eradicating it from those parts.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1232] PHILADELPHIA, OCTOBER 9, 1880. [Vol. XLIII.—No. 15.

Original Department.

Communications.

PLACENTA PRÆVIA.

BY GEORGE P. OLIVER, M.D.,
Of Philadelphia.

Perhaps, during the whole round of the obstetrician's professional duties, there is no time when he will need more presence of mind than when he is called to attend a case of placenta prævia. The suddenness of the attack, coming, as it does, without pain or warning of any kind, and when the patient is apparently free from any looked-for danger. The shock caused by the unexpected gush of blood renders the patient extremely nervous, and produces a degree of fear and depression, from which she is not easily rallied. The anxiety created in the minds of the relatives and friends tends to heighten the excitement, and to make the surroundings of the case quite embarrassing. In this trying scene the physician, in the exercise of his duties, will be required to exhibit a degree of complacency not usually manifested by individuals in the ordinary walks of life. In order that confidence may be fully established and his orders be quietly obeyed, his discretionary powers will be taxed to their fullest extent. Perfect composure should dwell on his countenance, and mildness should govern every sentence he utters. At the same time his mind must be clear and his action prompt and decisive. Deliberate judgment must mark and determine every movement in the treatment of the case. While he is *kind*, at the same time he must be *positive*. He will remember that precious lives are entrusted to his care. I have seen but a few cases of placenta prævia since I commenced the practice of medicine. I will give a short history of four cases, taken from my notes.

My first case occurred in the city of Philadelphia, in the year 1852. On the first day of June, about 10 o'clock in the morning, I was called to see Mrs. D., an American woman, twenty-two years old. She was healthy, with broad chest and well developed limbs; had dark hair and eyes, and weighed about one hundred and fifty pounds. I found her very much agitated, lying on a couch, on the first-floor of the house. She was dressed in her ordinary street clothes. Her mother, who was in attendance, informed me that she was enceinte, the first time, and had completed about five months of her pregnancy. That about half an hour before I arrived she had suddenly discharged from the "birth place" more than a quart of bright red-blood; and that no pain attended its expulsion, and that it was still flowing. The mother was very anxious that the daughter should not miscarry, and asked me to use every effort to check it, if possible. After making a proper examination, and satisfying myself as to the condition of the patient, I immediately made a tampon by rolling up a soft napkin, in a wedge-like form, and having immersed it in cold water, I introduced it into the vagina, pressing it up in contact with the uterus. I then ordered that the patient should be kept in a recumbent position, at perfect rest. After administering the eighth of a grain of morphia, and giving directions concerning the case, I left, and did not see the woman again until 9 o'clock that evening. Finding my patient sleeping and apparently very comfortable, and learning that she had been asleep

for two hours, I did not disturb her, but left her, as she was, for the night. On the next morning I removed the tampon, and found that a very small amount of blood had escaped during the twenty-four hours. I placed a dry napkin in the vagina, and did not see the patient again that day. On visiting Mrs. D. on the morning of the third day, I found her sitting up in an arm-chair, looking well. On removing the napkin from the vagina, I found scarcely a trace of blood visible. She at once resumed her household duties, and appeared as cheerful as ever.

On the 30th day of the same month, precisely four weeks from the time I had left Mrs. D., I was sent for again, and found my patient in the same condition I had seen her on the first day of the month. I pursued a course of treatment precisely similar to my first course, and the same good result followed. My patient was all right again within three days. During the interval from this time until the 13th day of October I was called three times more to see her, to witness each time a similar scene, to administer the same kind of treatment, and to see the same relief follow.

Four months and twelve days passed away, from the time of my first visit to Mrs. D. During that period she had five attacks of bleeding, and lost, perhaps, half a gallon of blood, yet she did not appear to have become very much weakened by the loss. On the morning of October 13th I was sitting in my office, writing; a woman came in, who was so bespattered with blood that I did not recognize her until I heard her voice. The woman was the mother of Mrs. D., who asked me to come at once to her daughter, who had been attacked a few minutes before with a very severe pain in the lower part of the bowels, and that the pain had continued with such violence that she was afraid it had "broken something inside of her." In less than five minutes I was at her bedside; she was in great agony, pain following pain in rapid succession, with an interval of scarcely a minute. A large quantity of blood had been ejected from the uterus, splashing the wall at a distance of three or four feet from where the patient was lying. A portion of the bed clothes was saturated with blood, and a small stream of fresh blood was running off the mattress, down to the floor.

I made an examination and found the os uteri largely dilated, with the placenta extending entirely across it, and adhering on all sides. A rupture through the body of the placenta readily admitted my hand. The torn and bleeding vessels of the placenta were pouring out a large quantity of blood. I at once passed my fingers around the inner edge of the mouth of the uterus, and by insinuating them between the placenta and the walls of the uterus, I succeeded in dislodging the entire placenta and bringing it away in one mass. The discharge of blood following the removal of the placenta, was enormous. After severing the cord, I proceeded to turn the child, which was accomplished with little difficulty, by bringing down first the right leg and then the left one; and by continued traction on the lower limbs and body of the child the delivery was effected in a very few minutes. It was a female child, and appeared to be dead. With much effort the child was resuscitated. For more than six months the child remained very small and puny-looking, appearing at times almost like a skeleton. The child continued feeble in body and mind for many years, and her menstrual period did not commence until her eighteenth year, and even after puberty she did not manifest very great intellectual powers. The girl was married when she was twenty-two years old, and is at the present time the mother of three living children; all seem to possess about the same amount of brightness usually seen in children of the same age in the same condition of life. They do not appear to have inherited either the *mental* or the *physical* weakness of the mother. Mrs. D. recovered within a month, but has never been pregnant since.

On the twenty-fourth day of June, 1854, late in the afternoon, I was called to see Mrs. J., an Irish woman, on north Second street in the city of Philadelphia. She was a short, stout, light-complexioned woman, thirty years old, and was pregnant the third time. When I entered the sick woman's chamber I found three midwives in attendance. They appeared to be employed chiefly with their tongues, and they were all talking at the same time. From the vehemence with which some of the sentences were uttered, I am not quite sure, but I think they were quarreling. As soon as I entered the room Mrs. W., the oldest midwife of the three, came to me and said, "Doctor, here is a case of *breech presentation*; there has been a dispute between the other two midwives and myself; they both contend that the *woman's womb has turned over*, and that the child cannot be born until the *womb is turned back again*." This midwife also said "that she knew something about this business, as she had attended at least a hundred confinements in her life, and had seen among them plenty of cases just like the present one." I had a few minutes' conversation with Mr. J., the woman's

husband, and learned from him that his wife had been in labor nearly twenty-four hours; that Mrs. S., the first midwife sent for, seeing a discharge of blood when she first came, said that the confinement would soon be over, as Mrs. J. had a *good show* already. After this midwife had remained about twelve hours, and the pains had become very severe, and the *show* seemed to be increasing, and as no other favorable sign was visible indicating the appearance of a child, the husband became alarmed and sent for another midwife, and after ten hours more a third was sent for. The trio now spent another two hours quarreling among themselves, which so disgusted the husband that he concluded he would have medical aid, and sent for me, imploring me to save his wife's life if possible.

I examined the woman and found, instead of a breech presentation, that the os uteri was largely dilated, and the body of the placenta was packed tightly in the opening. While I was attempting to loosen the adhering edges of the placenta from the left side of the mouth of the uterus, a violent pain came on, carrying the placenta, with much force, out of the uterus and down through the vagina to the outside of the vulva, and bringing the head of the child into the vagina. As no other pain followed, after waiting a few minutes, I put on the forceps, and delivery of the child was effected at once. The child was dead. The uterus contracted and no unusual hemorrhage occurred after the delivery. Mrs. J. informed me that she had had her regular monthly sickness three different times after the sixth month of her pregnancy. She made a quick recovery, as she was well within three weeks from the date of her delivery.

On November 20th, 1875, Mr. O'N—l came for me, with a message from Mrs. K., a midwife, asking me to come as soon as possible and bring my forceps with me. On my way to Mr. O'N—l's house he told me that his wife was bleeding to death; that this was her first confinement; that three weeks before that time Mrs. K., the midwife, thought that Mrs. O'N—l would be confined, but the bleeding had stopped and did not return again until to-day; that the midwife had told him that this was a case where the afterbirth comes before the child, and that it is very dangerous. When I arrived at the house I found the patient was a healthy Irish woman, twenty-two years old. She had been in the United States about three years. The midwife informed me that she had been with the patient eight hours and did not discover until half an hour before that the afterbirth had grown over the mouth of the womb. She said the woman had bled a great deal; that the pains had been very strong and frequent, in fact, they had continued all the time. I made an examination and found the os uteri sufficiently dilated to allow the head of the child to pass, but the placenta was covering the entire space and adhering firmly to the left side of the lips of the uterus. The loosened, ragged edges of the placenta could be felt on the right side of the os uteri. With each pain a small stream of blood, was poured out. I immediately inserted the first and second fingers of my right hand between the lips of the uterus and the adhering edges of the placenta, and passed them slowly upward on the inner surface of the uterus. By this action the placenta was loosened and the discharge of blood was greatly increased. I pulled the placenta away, and after tying and cutting the cord, I proceeded to turn the child, by bringing down the legs and continuing the traction until the shoulders were entirely free, then by putting my fingers into the mouth of the child, the delivery was effected at once. The child looked very blue, but with some little manipulation about the chest it was not long before it commenced to cry, and in a few hours it was as bright as it possibly could be. In two weeks Mrs. O'N—l was up and well.

I will describe one more case which I attended in the summer of 1879. In the early part of July, Mrs. G., a Jewish lady, thirty-two years old, called on me and engaged me to attend her in confinement, which she said would occur about the middle of August. She was pregnant the third time. Her husband, who accompanied her, told me he had made arrangements to take his family, for a month, to Appleboughville, a country town forty miles from Philadelphia, in Bucks county, Pennsylvania; that he selected the place on account of its privacy, as it was nine miles away from any railroad station. He also assured me that if anything should happen to his wife requiring my services, he would at once inform me by telegraph, and in less than three hours I could easily reach the village.

Mr. G., and his family left, and in a few days I received word that they were pleasantly enjoying their cosy little retreat. During their sojourn in that quiet region I received word from the lady several times, and everything went along smoothly until the morning of August 1st; as Mrs. G. was returning from a short carriage ride she was suddenly startled to find that, without any previous pain, or warning of any kind, about a pint of warm blood had issued from the vagina. Mr. G. was so much alarmed that he not only

sent a telegraphic despatch to Philadelphia, for me to come as soon as possible, but he also called in the only physician in the village. The Doctor was very timid and sent immediately to Doylestown, which is nine miles away, for two older physicians in consultation. The telegraphic despatch sent for me by Mr. G. did not reach me until twelve o'clock noon. The next train did not leave until two o'clock, P.M., and as the last nine miles of my journey had to be gone over in a wagon, on a country road, I did not reach my patient until six o'clock in the evening. When I arrived I found that three physicians had been in attendance; two of them were at the bedside, and they appeared more scared than the patient herself. As the treatment of the patient, up to this time, had consisted almost entirely of *talk*, and as a great quantity of it had already been dispensed, without any good result in the case, and as both of the doctors said that they had several pressing calls to make, they were much pleased that the family physician, from Philadelphia, had arrived so opportunely. The case was given entirely into my charge, and both physicians left. One of them, as he was leaving the house, stated that the woman would die before morning, and as the city doctor had her in charge, one of them would be saved the trouble of writing the *death certificate*.

I immediately had Mrs. G. placed on her back, in bed, and introduced a tampon, and the lady assured me that she felt much better. Before retiring, I gave my patient the eighth of a grain of morphia, and she slept well all night. I slept in an adjoining room, and was not disturbed the whole night. In the morning I removed the soiled tampon, and introduced another; the bleeding had entirely ceased. As I had left Philadelphia in a hurry, and had left a few patients who were expecting to see me that day, and as I believed the confinement of Mrs. G. would not take place for a week or ten days, I made a proposition to take Mrs. G. to her home in Philadelphia. The two physicians who had resigned the case the evening before, hearing that my patient had not died, and learning that I intended to take her to Philadelphia, both of them, without invitation, ventured back again, and bitterly opposed the removal of Mrs. G. to Philadelphia. The village doctor said the woman would die before she had gone three miles of the journey. Having procured a light spring wagon, I had a mattress placed in it, and after having introduced a fresh tampon, and having bandaged my patient properly, we placed her in a recumbent position in the wagon, and drove slowly, nine miles, to the railroad depot. We here transferred her to a comfortable bed in the railroad car, and arrived safely in Philadelphia, about five hours after we left the village. Not one ounce of blood passed from her during the whole journey. For five days I visited Mrs. G. once or twice every day. She was up and walking about her room every day, and she slept well at night. No bleeding had occurred since her arrival home. A folded napkin had been used as a tampon, and a fresh napkin was introduced every ten or twelve hours. She had a craving for food, and was allowed to partake freely of eggs, bread, rice, potatoes, milk, tea and coffee, and moderately of beef and mutton. Her bowels were opened once every day. Her pulse ranged from 75 to 80 to the minute. On the 6th day of August, on the removal of the tampon, she discharged about a quart of blood; no pain whatever attended the bleeding.

On the 7th day of August my esteemed friend, Doctor Richard J. Levis, of the Pennsylvania Hospital, saw the case in consultation with me. The use of the tampon was continued. No other treatment was used. For five days longer a very small amount of blood was discharged, perhaps a teaspoonful each day.

On the morning of the 12th day of August, I was called in haste to see Mrs. G., who was complaining of severe pains in the lower part of the abdomen, accompained with a gush of blood at the commencement of each pain. In making an examination, I at first thought there had been a hole torn through the body of the placenta; but after a more careful examination I discovered that the placenta extended only about one-half of the distance over the mouth of the uterus: that it was firmly attached on the left side of the uterus, with sufficient space on the right side for two or three fingers to be readily admitted. My first impression was to remove the placenta at once, by peeling it off of the inner wall of the uterus, and then complete the labor by turning, but as there was scarcely a minute of interval between each pain, and as the head of the child was descending with much force, I thought I would wait a little longer, and when there was sufficient dilatation of the os, rupture the membrane and use the forceps. I did not have to wait long. The pains continued to follow each other very rapidly, and as each pain brought with it the discharge of a large amount of blood, I was commencing to feel very anxious for the speedy delivery of the child.

During a severe pain I ruptured the membrane. After the escape of the liquor amnii a

temporary lull of the pains took place for a few minutes. While I was preparing to introduce the male blade of my forceps a pain came on, with a force seldom witnessed, bringing the head of the child entirely out of the uterus and exposing the vertex outside of the lips of the vulva. Of course, my task was a very easy one now; with the next pain I introduced my index finger into the mouth of the child, and the delivery was but the work of a minute. After severing the cord, I passed my hand into the vagina and inserting my fingers between the placenta and the uterus, with a very little effort loosened the placenta; there was a slight gush of blood, perhaps an ounce or more passed, but on removing the placenta, the uterus firmly contracted and no unusual discharge followed. The child was alive, but was very small and weak. As it was a male child, and as the parents were Israelites, it became a question of serious consideration with me whether this delicate little being could possibly survive the severe shock which would result from circumcision, if it should be inflicted upon it on the eighth day from the time of its birth. I had a conversation with the family and the friends and asked if the operation could not be delayed until the child became stronger? Although they said that such a course had been pursued in some rare instances, yet after a conference with the gentleman who was to perform the operation they agreed that the circumcision should be performed on the eighth day. The ceremony took place, and just six weeks from the date of its birth the child died. Perhaps it would not have lived, even if the circumcision had not been performed. Mrs. G. convalesced very rapidly. She was entirely well within a month. Her lochial discharge lasted only nine days.

From these four cases we may glean a few facts worth remembering.

1st. Scarcely any medication was necessary.

2d. Styptics were not used.

3d. The tampon and rest in the recumbent position were the remedies chiefly relied upon.

4th. Turning was not necessary in every case.

It is true that no positive rules can be laid down to govern the obstetrician in the management of cases of placenta prævia. Very much will depend upon his own good judgment and his aptitude in applying the means he may possess in such a manner as to secure beneficial results in the cases he may be called upon to treat. However, the notation of a few general directions will not be out of place in this paper. One of the first things to do is to make a thorough examination and ascertain whether it is a case of placenta prævia; use the speculum, if necessary, and find out if the placenta covers the entire mouth of the uterus; if it does, the management of the case will be very different from a case where the os uteri is but partially covered. You will also learn the duration of the gestation, and whether more than one attack of hemorrhage has occurred during that period. Find out if the discharge came on suddenly and without pain, as a knowledge of all of these facts will be necessary to determine you in your diagnosis and treatment of the case. When you have made out a clear case, if the woman is not in labor, your first duty will be to arrest the hemorrhage as soon as possible. This can, perhaps, be more speedily effected by the use of the tampon than by any other means you may have at hand at the time. A soft towel or napkin adroitly folded and placed in the vagina, so as to come in contact with the os uteri, will answer the purpose as well as anything else. Styptics, in these cases, are of little consequence, where they are not followed by the tampon, creating pressure directly upon or near the bleeding vessels. If you should conclude to use styptics perhaps the best are tannic acid, alum and persulphate of iron.

Placing the patient in a recumbent position, is an injunction which must be strictly enjoined. Have the hips elevated, by placing a bolster or any soft roller of muslin under the body, in the lumbar region. By these means you will generally control the hemorrhage for the time being. Ergot has been recommended, but if the os uteri is rigid, and there is no dilatation or other signs of labor, I would say do not use it, it will do more harm than good. As the patient, from the loss of blood, has become weakened in body, and from the fright experienced is suffering great prostration of the nervous system, the physician in issuing his directions will express himself in language suited to the temperament and condition of the patient. While dispatch may be necessary in everything done, yet the physician is not to bluster or allow others to do so, in the presence of the patient. Excitement on the part of the patient, or the relatives, or the friends, is to be checked as soon as possible. The strength of the woman is to be kept up by light farinaceous diet, and by drinking plenty of cold water. Little or no medication is requisite. Mild encouraging language from the medical attendant will do more good in overcoming the nervousness of the patient than any other means we can use. Nothing will be gained by harsh or dis-

agreeable words. If the patient should be restless, an anodyne may be given before the physician leaves the patient to the care of the nurse. Should the physician leave the patient, he will return in eight or ten hours; if the patient is not sleeping, he will remove the tampon, and if no bleeding takes place, he will introduce another, and direct the patient to remain perfectly quiet, and perhaps the whole difficulty will pass away, for the time being. If the bleeding has not stopped, he will immerse the fresh tampon in cold water, before it is introduced into the vagina. If labor-pains are present, an examination will be made, with a view of ascertaining if any dilatation of the os uteri has taken place. If labor has really commenced, and the os uteri has become largely dilated, it is the imperative duty of the physician to effect the delivery as quickly as possible, if the same can be done with perfect safety to the woman. Every effort is to be made to save the life of the child as well as that of the mother; but if it is found that the life of the woman is being imperilled by any delay, the delay must not be continued, but the delivery must be effected whether the life of the child is saved or not. This procedure is entirely proper in all cases where there is danger of the woman losing her life. If with each pain a large quantity of blood is lost the placenta is to be taken away at once. This may be readily accomplished by passing two fingers of the right hand between the lips of the uterus and that part of the placenta that is still adhering and gently peel the placenta away from the uterus. As the adhering surfaces yield to the action of the fingers, there will be an increased flow of blood, for a few minutes, but a little force used upon the body of the placenta will almost always cause it to fall into your hand. As soon as the placenta is taken from the vagina tie and cut the cord. Then ascertain the position and condition of the child. If the head is within reach and the bleeding still continues, put on the forceps and effect the delivery at once. If the woman is not worn out by a protracted labor, delayed, perhaps, by the ignorance of a midwife, the womb will contract almost as soon as it is emptied of its contents. If it is deemed by the physician impracticable to use the forceps, pass the hand into the uterus, bring down the legs, and deliver by turning. If the uterus does not contract readily after the delivery of the child, and the hemorrhage continues, grasp the uterus, through the abdominal walls from the outside, and knead the abdomen with the hands, and contraction will almost always follow. If the mouth of the uterus is but partially covered with the placenta and you find there is sufficient room for the passage of the head, your procedure will be to deliver, if possible, without taking the placenta away, but even here you will not delay too long, waiting for nature, as hundreds of little blood vessels from their open mouths are pouring out the life current of the patient, and will continue to do so until you have effected the delivery of both the fœtus and the placenta.

Two features I have noticed in all the cases of placenta prævia I have ever seen. One is, the pains follow each other more rapidly than in ordinary cases; the other is, the expulsive power of the womb appears to be much greater than it does in cases where no abnormal condition exists. I know of no writer who has mentioned either of these facts. Might not this phenomena be accounted for on the following hypothesis: That the expelling power of the uterus resides entirely in the contractile fibres of the fundus and the body of the uterus, and not in the cervix at all, and as the placenta in these cases covers no part of the fundus and but a small portion of the surface of the body of the uterus, those parts being free from adhesions, the uterus is allowed to perform its functions more readily than if a larger portion of its contractile fibres were adhering to the placenta. This is merely an idea of my own, and as such I give it for whatever it is worth. I have seen cases of hour-glass contraction of the uterus, where the placenta was attached to the fundus and the upper portion of the uterus, and the uterus seemed to be very flabby, on account of the adhesions existing, while the fibres of the middle portion were firmly contracted, because they were free to act, having no body of any kind attached to them. It is a well known fact that in any ordinary case of labor, when we have freed the inner walls of the uterus from contact with the fœtus and the placenta, as a general thing, contraction takes place at once.

936 *North Fifth Street.*

Hospital Reports.

BELLEVUE HOSPITAL, N. Y.

CLINIC BY WILLIAM H. THOMSON, M.D.,

Professor of Materia Medica and Therapeutics in the University of the City of New York.

We pass to-day, gentlemen, from phthisis, a very easily recognizable disease in the majority of cases when fully developed, on account of external symptoms that are suggestive of the disease, as well as on account of a clear and cou-

nected history, to a disease which has no external symptoms peculiar to it, and whose history may be so diverse in a given case, from that of any previous case in your experience, that you will scarcely recognize any similarity between them. You will hardly find an affection whose manifestations are so numerous, so dissimilar, and frequently so obscure, as are this one's. To illustrate this, let us study these cases.

In the first place, you do not notice in the appearance of either of these three patients any indications of disease of any of the organs in the several visceral cavities, unless it be in this patient, No. 1. He has a corrugated forehead, and that may slightly point to some one of his symptoms. We do not know whether it does or not, but certainly he has not very much trouble with the chest, although he has a little dyspnœa, which I notice already. Perhaps he has had some trouble about the chest. There is not anything very distinctive about the appearance of his mouth, to show whether he has any trouble in the abdominal cavity. The second patient certainly does not show in his appearance trouble with any of the organs in the several visceral cavities. No. 3 has a frown on his forehead, and is emaciated. No. 1 is partially emaciated. No. 2 is not at all emaciated. And so you will find in taking the external aspect of the patient, there will be perhaps but one thing which will lead you to suspect his disease, and that is the color of the skin, but that is not uniformly the same. As to the history, it will differ in every one of them.

How long have you been sick? (No. 1.) "About six weeks." How were you taken sick? "A hard cold and shortness of breath, and cough." I told you, gentlemen, this man had some dyspnœa, evidently. Why so? Because he keeps his mouth open, and that is characteristic. It is not because the man is lazy, and has, according to the old saying, "a fly-trap in his mouth." It is not that at all. It is the mouth that is very slightly open, with the lips drawn wholly over the teeth, that indicates trouble with the breathing. It is the open mouth with the lips hanging loosely down, with an expression of stupidity, that comes from laziness.

Well, your sickness began with a cold; you had a cough and shortness of breath, but you never had any trouble before that; and since you came into the hospital, you have got a good deal better; your breathing is better and your cough is better. Have you anything else to tell about your sickness? You did not have any swelling? "O, yes. Swelling about my ankles." Why didn't you say so? "I forgot it." Most people would not forget that.

How long have you been sick? (No. 2.) "About five months." What did you first notice? "Swelling about my feet." Did you notice anything else? "No, sir." You did not have any headache; had no sickness of the stomach; no shortness of breath? "No, sir."

How long have you been sick? (No. 3.) "About six weeks." You were pretty well before that, were you? "No, sir. I have been out of sorts for a good while; about nine months." But this trouble which you have now has been of about six weeks' duration. Were you able to do your work last year? "Yes, sir." You are a laboring man. What was the first thing that made you sick nine months ago? "I got a cold, a very bad cough, and a weakness of the stomach. Would throw up my victuals." Which was the worse, the weakness of your stomach or the cold? "The cold. Would throw up my food in the morning. Did not have any pain in the stomach." Did it feel comfortable when you got rid of your food, or did it feel bad? "Always felt bad." Would you throw up if you had no food on the stomach? "Yes, sir." I want you to note that, gentlemen; he had nausea at all times; that is, sometimes, whether he had anything on his stomach or not. When you threw up, then, what kind of matter did it appear to be? "Water. It was burning hot. Had no color about it."

What happened to you six weeks ago? "About the same." How about your cough? "It got worse; and my stomach got worse." Did you ever have any swelling about you? "Yes. My legs used to swell once in a while." I am impressed, gentlemen, that his is not a typical case of the disease; that there is a cardiac element in it. On examination, I find my impression was correct.

Well, now, here are three cases of the same complaint, and their symptoms are not by any means the same. In the first patient, the first thing that attracted his attention was a cold with cough, and shortness of breath; and this cough got worse. Along with it, which he had forgotten about, as if it were a minor matter, he had water-leg, or dropsy of the feet. The second patient complains of nothing but swelling, and if it were not for that he would probably consider himself well. The third patient had, along with a cough, sickness of the stomach; and he used to vomit, not because his food disagreed with him, but because of sickness of the stomach. So I might go on and show you case after case, in each of which the story would be different. A fourth case will tell us that the first thing he noticed was a headache; and that he had it a great deal, along with nausea. A fifth case might say he did not notice anything until his sight began to fail; that he thought he must be growing old, or that something was wrong with his sight; it grew dimmer and dimmer, until finally he went to the oculist, who discovered the cause of the trouble. Another patient has nothing but an attack of diarrhœa, and this diarrhœa will not get well; it keeps on and keeps on, and he comes to you on account of this persistent diarrhœa. Another patient comes to you with difficulty of breathing, and absolutely nothing else. You examine him, and find that he has pleuritic effusion of which he was not aware. He was so little sick from pleurisy that he had all this trouble without being at all aware that he had a real serous inflammation. Another case will be waked up at night, for the first time, with asthma. He never had asthma before; had lived all his life up to the present time, without an attack of asthma; he went to bed apparently as well as anybody, but woke up in the night with intense difficulty of breathing. And so on. I think it would be a real curiosity for any physi-

cian of extensive practice to look over his notes, and see if he could find any two or three cases of this disease presenting the same symptoms. Hence it is that this disease is so often overlooked. It may present the symptoms of almost any disease of the body.

Here, for instance, is a case of cough; here a case of swelling of the feet; in another case there will be diarrhœa or dysentery; another, the symptoms of nervous derangement; another, simply general loss of strength, a feeling of weakness, and the patient does not know what is the trouble; another patient still will come to you for dyspepsia; he is so very bilious, has been becoming more and more bilious since eight or nine years back, until now he vomits his food. I think I have seen within the past year patients with this disease whose attention was first attracted in the different cases to trouble in every different organ of the body, from head to foot; and it is for this reason that Bright's disease of the kidneys is more frequently overlooked, until it has advanced to the last stages of the disease, than any other affection. It is the one disease that you must always be on the lookout for, and hence it is your business to ask every patient who comes to you for a specimen of his urine, it matters not what he comes to you for. I once heard a story of a doctor, imperfectly educated, and imperfectly furnished in his brains, probably, who was so stupid that it was a wonder to all his friends how he got through a medical college. He asked an old physician what he should do first when a patient came to him for treatment. He told him to give him an injection. Well, the first case that came in was a case of dislocation at the shoulder joint, and he insisted upon giving the man an enema right away. The man resisted, and in the struggle got the dislocation reduced. Nevertheless, it is a good routine practice to ask for a specimen of the water. It is not necessary in a case of shoulder joint luxation, probably, but if it is a medical case, not a surgical one, by all means examine the water and see what may be its condition; but I will say this, that even that may not give you much information with regard to Bright's disease. There may be present the worst form of Bright's disease with very little evidence of it in the urine. Albumen is present in about half the cases of Bright's disease when it has lasted six months. You may take that as a rule, that in about half the cases of six months' duration albumen will be found in the urine. In the other half it will be absent. We would not have dreamed five years ago that the proportion between the cases of presence and absence of albumen in the urine in Bright's disease was so nearly equal. It was supposed to be present in the majority of cases. Albumen is probably absent in about one-third of the cases of Bright's disease, from the beginning to the end of the disease; that is, they do not have albuminuria, or if they do it is only occasionally, so that it would be very likely to be overlooked, even if the urine were examined quite frequently. This has been shown in the published statistics of some European hospitals lately. The number of cases in which the disease has not been discovered previous to death, but in which it is manifest at the post-mortem examination, is irresistible proof that it does not indicate its presence in the urine by any of the tests yet known.

Unquestionably, the real test of Bright's disease is the amount of urea eliminated in the twenty-four hours. Now, that is a complicated thing to make out. It is a very difficult thing to discover, except by a very careful chemical analysis. An illustration of this: Within the past week a friend disagreed with me with respect to the nature of a given case, he ascribing it to malaria, I to Bright's disease. He said the urine had been examined repeatedly, and no indication of Bright's disease had been found. To settle the point, we had some urine examined for the amount of urea passed in the twenty-four hours. One day it was only thirteen grains, another only fourteen grains, for the whole twenty-four hours, and on another day it contained only eight grains, and then it went up to forty-four. Now, you know that this last figure is not nearly high enough for a healthy person; and it matters not how much fluid the kidneys are passing, they are passing water, not urine. And sure enough, the specific gravity in this case went down one day to 1.001, another day 1.003, another day 1.008. Now, a patient passing such urine as that would sooner or later have uræmia. This patient's urine had been examined for albumen and casts, and examined very carefully, too, but none was found; and yet it was a true case of Bright's disease for the time being, and I believe it has been a case of Bright's disease all along; the kidneys are not working, and hence the patient's anæmia, and headache, and pleurisy, all of which were present, due to a condition of the kidneys causing uræmia, rather than to malarial infection.

Now, this shows that you can by no means, in a suspected case of Bright's disease, simply take a specimen of the urine and examine it, and pronounce a correct diagnosis of the patient's trouble. You can more easily say that it is a case of Bright's disease, than that it is not. Now, how can you tell whether the kidneys are not doing their work; whether the blood is poisoned, capable of destroying your patient by toxæmia? A low specific gravity of the urine, considered in connection with the amount passed, will enable you to tell pretty well whether your patient is in a uræmic condition or not, no matter what the other signs may be. A patient is a great deal worse off passing a small amount of urine of a specific gravity of 1.008, without any albumen, than if he were passing a good quantity of urine of a specific gravity of 1.020, being half albumen. I would, myself, a good deal rather be passing a half quantity of urine one-third albumen, of a specific gravity of 1.025, than to be habitually passing watery fluid the specific gravity of which is 1.006; for I know that in the one case the albuminuria may be recovered from, but in the other case, if it is habitual, it points to a seriously damaged kidney.

Hence, as to the prognosis. If you can once get the kidneys to secrete urine of 1.025 in specific gravity, and in quantity a pint and a half for the twenty-four hours, you can give a good prognosis, no matter how much albumen may be present. The prognosis is yet good, whenever the kidneys

can secrete enough of the salts to bring the specific gravity of the urine up to 1.025. The case may be a very sick one, but the kidneys are not so far damaged but what they can do their work. But we are frequently called to cases that have continued so long that no symptoms in the constituents of the urine remain; the kidney in great part has been washed away, and you have an organ that is, the greater part of it, consisting only of the free, clean tissue, incapable of repair.

Consider a case like this patient's, whose trouble began with a cough. He had no swelling of the feet, nor of any other part; one half, at least, of the true cases of Bright's disease do not present this symptom. He had a violent cough, but you noticed he had a good deal of dyspnœa with the cough, which is not of long standing, and therefore it is not due to ordinary bronchitis. Now, suppose his dyspnœa were due to ordinary bronchitis, how would he behave? His shoulders would be elevated, and he would rub his chest in an indefinite way, showing that he had a great deal of oppression of the chest, as it is usually called. Pain and soreness and fever, with febrile excitement and redness of the face, will all indicate to you that it is an ordinary case of bronchitis. But suppose a patient comes to you breathing with difficulty, without any fever, without soreness, but has a cough of recent date; it should lead you to suspect at once that the dyspnœa is due to kidney affection causing blood poisoning.

You should next note the pulse, and here you should get a sign which is almost never absent. But you should begin by examining the arteries before feeling the pulse. This patient has a somewhat hardened artery; it can be felt at this point, but not up there. It should not be apparent to the touch anywhere in the young person, or in the very healthy older person. If they are emaciated, it can be felt about here. In this patient it feels somewhat hard, as I said, like a cord or tendon. Now, no healthy artery ever feels so. That means that the artery is thickened; and now the question arises, is it thickened by old age, or is it thickened by the poisoned condition of the blood? If it were thickened by old age it would feel rough, irregular; there would be atheromatous patches in it. Sometimes, in the old person, they are so easily distinguished that the artery feels like a string of beads. In this case, however, the artery is perfectly smooth. It is more like a smooth wire, which indicates that it is thickened uniformly, and therefore by a uniform cause, which is the condition of the blood.

Now, I feel of the pulse. It is an incompressible pulse; it beats under all four fingers with which I am feeling it. It beats so plainly that it requires a great amount of pressure to stop it. Although I am making considerable pressure on it with the proximal fingers it can be felt under the distal finger.

Now, there is another thing to be learned, and that is, whether this artery is very much thickened or not, and that I find out in this way: if it is very much and permanently thickened, by pressing firmly on the artery here with these two fingers I obliterate the current of blood in the artery further along, and still the artery can be felt. In this case, after stopping the flow of blood through the artery I cannot feel it. Therefore, it is not very much thickened. You understand that point? It is a very important point. You want to know whether an artery is hard because it is overfilled with blood which does not run out of the artery easily at the distal end, and therefore causes this cord-like feeling, or whether it is due to a thickening of the walls of the artery. If it be due to a thickening of the walls of the artery, when the current of blood is checked at a given point by pressure above, the artery will still be felt below. On the other hand, if it be due to overfilling with blood, the empty artery below the point of pressure cannot be felt.

Now, in this patient you can feel the artery, although you make considerable pressure above, but on stopping the flow of blood entirely, it cannot be felt. In another case you might find that, no matter how much pressure you made above, you would still find the artery lying in its bed below. If so, it indicates that the artery is quite thick, turned into something like a cord, and it probably has a very narrow caliber.

Now, that incompressibility of the pulse is to be explained in this way, and it is *the* feature of the disease. I think, that if I were blindfolded, I could go into a room and pick out at least two-thirds of the cases of Bright's disease, by the pulse alone. You notice that you have a very pale skin here. The anæmia of Bright's disease is characteristic. It is a perfect whiteness of the skin. You see it in the appearance of his hands. There is a paleness of that hand which is not present in any case where this disease is not present. And what is a more striking fact is, that you cannot redden it. You may rub and rub, and try to get the capillary circulation started in that skin, and you cannot do it. What is the reason of that? "The capillaries are obliterated." Yes, the little arteries are obliterated in this complaint, and hence the embarrassment of the circulation, an actual clogging up of the capillaries lying between the peripheral arteries and the commencing veins. Now blood runs, of course, from the arteries through the capillaries into the veins, or should do so; but here we can rub and rub the skin and fail to cause any reddening, which indicates that the arteries cannot easily empty themselves into the veins.

Well, what is the result in the arteries? Necessarily, that they are constantly overflowing, and give you, therefore, that full pulse illustrated in this patient. When you come to press upon his artery, you will find that you will have to press, and press, and press, in order to obliterate the pulse, just as if you were to press upon a hose in which the exit of the water had been shut off by turning the stop-cock. If the stop-cock were open and the water allowed to run out, you would be able to compress it readily with your foot; but try to press it while the stop-cock is on, and you will fail. Precisely so with this patient's arteries. The exit from the arteries, through the capillaries into the veins, is clogged. If it were not, the blood would run freely, and the pulse would be compressible.

Now, you will see what a number of sequelæ will depend upon that principle. Many things

connected with this disease can be explained by that one fact. We will have a slow venous current, and as a result, a tendency to dropsy, which results from anything that causes slowness in the venous radicals. The tendency is greatest in parts where the venous circulation is not so much assisted by the surrounding tissues, as about the eyes. On this account, the earlier signs of Bright's disease are oftenest in the loose parts of the face, under the eyelids, etc. Where the muscles run along the course of the veins, their contraction assists in pushing the venous circulation on, by means of the valvular arrangement within the veins. But where there are no muscles, you will first find a tendency in the veins to show a failure in the propulsion of the venous circulation. Dropsy occurs whether you have a cause of venous slowness from behind or from before. It will be from before, for instance, in case of obstruction in the liver to the portal circulation, or in case of disease of the lungs, leading to embarrassment of the right side of the heart. It will be from behind, however, in Bright's disease. There is, as said before, very slow venous circulation in Bright's disease, from the embarrassment of the capillary circulation. This is one of the explanations, at any rate, of the dropsy of Bright's disease; and the explanation of why it should first occur in the loose tissues of the body.

From the derangement of the kidneys there arises an obliteration or a thickening of the walls of the capillaries and of the arterioles, which leads to an overfilling of the arterial system. And this implies danger in the arterial system. What danger? Not aneurism, but a giving way of the arteries of the brain. They are the ones that will most commonly give trouble. Aneurism is more commonly the result of some local disease of an arterial coat, whereas in Bright's disease the entire arterial system is affected; but it will most affect the arteries of the brain, because they are not supported. The tissues that surround them give them no support whatever, and hence they are much more liable to give way. The external tunica of the arteries there is made up of very weak material compared with what it is in other parts of the body, and the artery there is far more likely to rupture, or to give you small aneurisms that lead to rupture. Now, therefore, three-fourths of the cases, particularly of hemorrhagic apoplexy, are due to Bright's disease of the kidneys. That is a rule, and on that account it is important to understand this condition of things, for the purpose of prophylaxis. There is not a more important subject for you to study than how to prevent hemiplegia, because the nature of the accident is so terrible that anything that prevents it is infinitely preferable to having to deal with it after it has occurred. Now, the great cause of hemiplegia is Bright's disease of the kidneys. It is the commonest cause; so much so, that you will probably in ordinary practice have nine cases of hemiplegia due to kidney trouble to one due to any other cause than kidney trouble. Now, as to the indications of it. I do not believe I have ever seen a case of hemiplegia in which there was not this thickening of the artery and that incompressible pulse, which is so often mistaken for strong pulse. Now, you may say that a stron pulse in an old person is a very uncommo thing; but there are many old persons whos pulse feels strong, and is mistaken for such ove and over again. You will hear persons say, h has a good, strong pulse, when in reality he ha a weak pulse. It is this kind of a pulse tha will be mistaken for a strong one. It is on that you cannot compress, and because you can not compress it, you think it strong. But tha is a great mistake. The strong pulse is wholl dependent upon the heart. Never is the puls strong except as it is due to the heart. There fore, if you are in doubt whether the pulse i strong or not, examine the heart. If there is powerful impulse, and a clear sound, it indi cates a strong pulse; if there is not a stron impulse with the beat of the heart, and the firs sound is weak, it matters not how the pulse feels it is not a strong pulse. It cannot be, becaus the strong pulse is dependent upon a differen condition of the heart. Then, taking this condi tion of the arteries, which you are meeting witl all the time, in which they are overfull, you ca very readily make out whether it is due to want of elimination, whether it is toxæmic and if so, that person is in danger, sooner o later, of one of the arteries of the brain givin way.

Now here is the case in which we said there were indications of a cardiac affection also Feel his pulse, and you will see that it is both uræmic and an atheromatous pulse. It is like wire, but it is not uniformly so, like this one. On the other hand, you can feel that it is rough. The man is somewhat aged, and he has an atheromatous artery. His symptoms are, that he had a running sore in his leg for a number of years, and after he had had that for a good while he began to get sick at the stomach, and was unable to work. He said the sickness of the stomach occurred in the morning, but I have no question that it occurred at other times as well, and was not necessarily connected with his meals. That is a suspicious symptom, nausea coming on without any reason for it, so far as the food is concerned, that the patient can discover. Such patients very frequently ascribe it to biliousness. In a case of vomiting, if it be the first time it has come on, I always examine the water.

Now, after he had had this sickness of the stomach a good deal he began to be so weak that he was obliged to give up work. On feeling of his pulse I find it intermittent. There are two beats and then a stop; two beats and a stop; two beats and a stop; and then sometimes there is a double beat, an irregular dicrotism of the pulse. Well, I know, therefore, that this is not only a diseased artery, but that it has a fault at the centre of the circulation, for there are three elements in the pulse that tell you of the condition of the heart, and there are three elements of the pulse which belong to the condition of the blood vessel. The strength of the pulse always depends upon the heart, likewise the frequency and the rhythm. The heart alone has to do with these three elements of the pulse. This patient's pulse is weak, therefore

ıe has a weak heart, or at least it is working veakly now; it is slow, and that is because the ıeart is beating slowly; there is no other reason or that; it is irregular in rhythm, and that again s due to the heart. The vascular elements, hose dependent upon the condition of the artery, ıre, the fullness of the pulse; that is, whether t is a large pulse or a small pulse. Well, this is ɔne midway; it is neither large nor small. Next, whether it is a compressible pulse or an ncompressible pulse; that is, whether or not ɔu can compress it readily and extinguish it. Now, that depends upon the artery exclusively. In this case the pulse is rather incompressible. It beats under all four fingers, and it requires a ɔonsiderable amount of pressure to stop it. It s less compressible in the other patient than in :his. And lastly, whether it is a short or a long pulse. A short pulse is one that passes very quickly under your finger, makes only a little vibration and is gone. The long pulse, on the other hand, is one in which the vibration is prolonged. You can tell the difference between them by comparing this pulse with the pulse of phthisis. In the patient with phthisis I got a little, quick, shallow pulse which came and was gone, while in this patient, on the other hand, the pulse is three times longer passing under the finger. It requires a considerable amount of practice to mark that difference. If the blood runs out of the artery easily it will be a short pulse; if it cannot get out easily it will be a long pulse.

Now, this rhythm shows that there is some difficulty, either organic or nervous, at the source, the heart. It is very common to have valvular incompetence in Bright's disease; and it is simply due to the over-distention of the arteries, the heart finding it difficult to empty the blood into the over-filled arteries, and therefore the heart itself is constantly overfilled, and allows of a little regurgitation. Hence, during life, in the great proportion of cases of Bright's disease, you have cardiac murmurs, all kinds, obstructive and regurgitant. And very frequently in cases where you thought there was valvular disease of the heart during life you will find no evidence of it after death. In reality the over-distention in the arterial system had rendered the heart constantly over-filled with blood.

Medical Societies.

THE BRITISH MEDICAL ASSOCIATION.

(*Continued from page* 298.)

For the want of space, we omit giving any further abstracts of the addresses delivered, and will proceed at once to the more practical papers. Among the papers read in the Section of Medicine, was one on

The Curability of Attacks of Acute Phthisis (Galloping Consumption),

by T. M. McCall Anderson, M.D. By the term acute phthisis, the author meant an acute pulmonary affection, accompanied by high and continuous fever, running a rapid course, and leading invariably to more or less destruction of lung tissue if the patient survived long enough. He recognized three varieties of the disease: 1. Acute pulmonary tuberculosis; 2. Acute pneumonic phthisis; 3. Acute pneumonic phthisis complicated secondarily with the development of gray miliary tubercles. He thought it impossible to distinguish the second from the third variety during life; but that the first might be suspected when the disease set in suddenly with high fever, great prostration, profuse perspiration, lividity, and great acceleration of breathing, and when these symptoms were *out of all proportion to the results obtained from a physical examination of the chest.* Having given extracts from the writings of Walshe, Trousseau, and others, showing that the profession was very hopeless as to such cases, he pointed out that, in a good many cases, he had obtained excellent results from treatment, of which the following was an outline: 1. Careful skilled nursing, with constant feeding, and stimulants in small quantities often (from 4 oz. to 10 oz. daily); 2. Each night, a subcutaneous injection of $\frac{1}{100}$ to $\frac{1}{60}$ of a grain of atropin; 3. Remedies specially adapted to the removal of fever: (*a*) ice-cloths to the abdomen; (*b*) quinine, 10 to 30 grains, in a single dose, once daily; (*c*) a pill, composed of one grain of quinine, half a grain of digitalis, and from a quarter to three-quarters of a grain of opium, every four hours. In addition to this, special symptoms—diarrhœa, constipation, and the like—must be treated on ordinary principles, and, of course, the treatment indicated must not be used in a mere routine way, but adapted to the surroundings of each individual case.

The next paper was by W. T. Gairdner, M.D., on

The Treatment of Bright's Disease; with Special Reference to the use of Diuretic Remedies.

Dr. Gairdner had been long of opinion, as the result of more than twenty five years of hospital experience, that the English practice in Bright's disease, and especially in acute and sub-acute cases, had been too much founded on the conception that the kidney, like an inflamed organ, must have, as nearly as might be, entire physiological rest; and hence that diuretics were to be avoided, even at the risk of their requiring to be replaced by more perturbatory practice. Dr. Gairdner did not hold that diuretic treatment was alone sufficient, or even in all cases expedient; but he held that the mere abstinence from diuretic treatment, or the doctrine that such practice was to be regarded with suspicion in the cases in which the simpler saline diuretics could be brought to act, was opposed to the teaching of experience. In the London schools the teaching adopted for many years was that the occurrence of active diuresis, under remedies especially adapted to that end, was to be avoided, and that it was better practice, in most cases, and especially in acute and subacute cases, to aim at purging the bowels continuously by the strongest and most irritating cathartics, than to give scope to the kidneys to respond gradually and gently to such remedies as cream of tartar, potash salts, and digitalis. The position here referred to had been modified of late years by the admission:

1st. That spontaneous diuresis often, if not invariably, occurred in such cases as a kind of crisis, or as the first step in the cure; 2d. That (as Dr. Dickinson, in particular, had emphatically taught) the copious imbibition of "clear spring water," in quantities such as to make it practically one of the most active of diuretics, tended to the relief, rather than to the obstruction, of the kidney in its physiological work; in other words, that flushing of the obstructed tubili uriniferi, and general furtherance of the true physiological activity of the kidney tended (as Dr. Christison long ago showed) to the diminution of its pathological disturbance of functions, as indicated by albuminuria, deficient excretion of urea, and dropsy. Dr. Gairdner regarded it as in accordance with clinical experience, apart from the theory that, whenever the simpler diuretics would act at all in such cases as were usually treated by means of elimination, their action should be furthered and encouraged, in preference to other modes of elimination. While he did not at all discountenance the use of purgatives on the one hand, or of diaphoretics on the other, in cases in which they were specially indicated, or in which diuretics could not be brought to act, he was always disposed to make such simple diuretic practice as was indicated above the keystone of the treatment, and to consider it as more in accordance with nature, and with the spontaneous tendency to crisis above mentioned, than the use of the stronger drastic purgatives, or even of medicinal diaphoretics, or the too repeated and somewhat enervating use of warm baths, or of air and vapors at a very high temperature. Diuretics, indeed, not unfrequently failed; but so also, not unfrequently, did all the other remedies mentioned. It must also be admitted that the reasonable regulation of the skin and of the bowels was an essential part of good treatment in most cases of Bright's disease, whether attended or not with dropsy; and that in certain cases, *e.g.*, of immediately threatening uræmia, drastic cathartics were sometimes the only method that could be trusted for immediate relief. In such cases Dr. Gairdner acted on the presumptions derived from Bernard and Barreswil's well-known experiments, as well as on empirical data; showing that the elimination through the bowels of excretory matters which, if retained, were dangerous to life (and notably of urea and its congeners in the form of carbonate of ammonia), might be rationally and safely accomplished for a time, at least, so as to save life and conduce to present comfort. But he regarded this perturbative course as only a temporary phase of treatment, necessary in some cases, and to be supplanted as soon as possible by the more natural and physiological determination of the liquids towards the kidney.

By the judicious use of formulæ by no means complex, it was usually possible to graduate catharsis into diuresis, so to speak, in such a way as to gain whatever advantages resulted from the former practice, while at the same time seizing the earliest opportunities of inducing a true renal crisis, whereby the cure, if possible at all, was usually best completed. The exclusively diaphoretic practice of Dr. Osborne, of Dublin, seemed to have been tried and found wanting and in a measure laid aside, until recently revived in another form in Germany, particularly by Bartels, whose admirable articles in Ziemssen's *Cyclopædia* would probably give rise to new elaborate trials of Turkish and vapor baths. Dr. Gairdner had often employed these with benefit; but he thought that these benefits would be exaggerated, if they were so employed as to shut out diuretics, or to divert habitually, all the avaiable liquids of the body for long periods together to one emunctory, and so to starve the supply of liquids to the kidney. In a few cases of great obstinacy, however, a certain amount of temporary benefit appeared to result from the hypodermic employment of pilocarpin in doses of one-eighth to one-fourth of a grain every second day. The limits of expediency in the use of such perturbative and medicinal diaphoresis had, however, to be determined by careful further researches. The same remark applied, in Dr. Gairdner's opinion, to bloodletting, which, at one time a frequent and even a very favorite remedy in the acute and subacute cases, had in later years almost gone out of date, but which had been yet more recently revived by several observers and practitioners of good standing.

William Marcet, M.D., F.R.S., presented a paper on

The Influence of Altitude with Reference to the Treatment of Pulmonary Disease.

The author accepted the generally acknowledged theory, that cases of phthisis among the inhabitants of altitudes exceeding five or six thousand feet were so rare as to be exceptional. He also admitted that such winter stations as Davos might prove beneficial to consumptive invalids, and had in some cases apparently effected a cure. After reviewing the influence of altitude in disease with especial reference to the various descriptions of pulmonary affections, the author proceeded to account for the beneficial effects of such winter stations as Davos on consumptive invalids. He stated the results of his own experiments on respiration at various altitudes, which had a direct bearing on the present subject, and from which he arrived at the following results:—

1st. At stations at various altitudes above the sea, a smaller weight of air was taken into the lungs (or a smaller volume of air reduced to sea-side pressure and freezing point), while more carbonic acid was emitted, especially in a cold climate; and it followed that the oxygen of the air passed through the substance of the lungs into the blood more rapidly or more readily on mountain stations than near the sea level. 2d. Up to 7000 or 8000 feet, the increased volume of air breathed within a certain time (not reduced) was due to a greater expansion of the chest and lungs, and but little, if at all, to an increased rate of breathing, although at higher stations the frequency of the respiration was decidedly increased. The author concluded that the beneficial influence of high winter stations on the progress of phthisis was due: 1st. To the blood becoming more fully charged with oxygen from the air breathed, and to the phenomena of oxidation in the body being increased, thereby promoting considerably the

healthy changes in progress in the living body; 2d. To the capacity of the chest and lungs being increased—at all events, temporarily—after a winter sojourn in the mountains; and because, on that account, a greater volume of air was breathed after returning to a lower level. This last conclusion was arrived at independently of the observations and statements made by Dr. C. T. Williams, who offered a similar explanation to account for the beneficial influence of Davos in cases of phthisis.

In the Section of Surgery Gerald F. Yeo, M.D., first read a note on

The Application of the Antiseptic Method of Dressing to Cranio cerebral Surgery.

The object of the note was to give the results of experiments on the applicability of the antiseptic method of dressing to the brain and meninges, which were undertaken under the auspices of the Scientific Grants Committee of the Association. In the experiments, Dr. Yeo had had the great advantage of the advice and assistance of Dr. Ferrier. The experiments were performed on monkeys. Before the operation the scalp was purified with a strong (one in five) solution of absolute phenol in oil of glycerine. The spray was used in all but four cases. The edges of the wound were accurately brought together with sutures; horsehair being found the best. The discharge was so slight that drainage was unnecessary, and in the later cases it was omitted. Several layers of loose gauze, damped in a solution of carbolic acid (one in forty), were placed over the wound, and were held in position by about twenty turns of a narrow gauze roller, and the whole enclosed in three or four caps of gauze painted with collodion. The trephine was used for opening the skull, and a small bone-forceps was applied to shape the aperture to the required size. Of twenty-six animals operated on, only seven died; but in three of these the death might be attributed to the intense cold of last winter—one of these three survived the operation thirteen days without inflammation. One death might be assigned to chloroform. Of the remaining three deaths, one was caused by hemorrhage six days after the operation, there being no trace of inflammation; one by the shock of the operation; and one only by inflammation. Of the twenty-one animals which survived, twenty were treated successfully with antiseptic dressings, and one was treated with modified antiseptics. Among the cases treated antiseptically, there was not one case of inflammation; and where this method could not be used, there was intense encephalitis.

This was followed by an animated discussion on the treatment of wounds, in which several of the members took part.

Sir Henry Thompson, F.R.C.S., read a paper on

Lithotrity at a Single Sitting; with a Record of its Results in Forty-six Consecutive Cases.

The paper consisted of a consideration of Bigelow's proposal, with reasons for believing it would issue in an advance for the operation of lithotrity. About eighteen months ago Sir H. Thompson commenced employing it as the rule; and since that time he had operated in fifty-four cases of stone in the bladder of the male adult, mostly aged; on forty-six of these by the method of one sitting; on two others by multiple sittings; and on six by lateral lithotomy. Among these fifty-four cases were three deaths, two in cases of lithotrity by one sitting, and one after lithotomy. The reasons were given for adopting multiple lithotrity and lithotomy in the eight cases; and the following practical deductions were appended to the paper, as the sum of the lessons to be learned by this contribution toward an attempt to estimate the value of the method in question. 1. In view of a general adoption of lithotrity at a single sitting, it becomes more than ever important to diagnose carefully before operating, the size—and if practicable, as it mostly is—the nature of the stone, so that the means employed to remove it may correspond thereto. For, when the stone is small, or of medium size, as it is in the majority of cases, it is not only unwise, but dangerous, to employ large and unwieldy instruments to remove it. Small instruments are much safer than large ones, and do less mischief in the bladder and urethra. The latter should never be used, unless the work to be done renders them necessary; and this can only happen in a few exceptional cases. 2. There is no doubt that a practiced hand, thoroughly familiar with the details of lithotrity, is more necessary to the success of an operation which is to be completed at a single sitting, when the stone is not small, than to that of an operation which consists of several sittings. In other words, the removal of a large stone at a single sitting is a more difficult proceeding than that which disposes of it at several trials. 3. Speaking with caution, it appeared to him that at present we are not justified in attempting to remove all stones by crushing, and certainly not by any one system of crushing. The new method rendered lithotrity safer than before, for the stones already assigned to that process, and extended it to some which were larger than before so operated on. But he still regarded lateral lithotomy (the high operation being sometimes, perhaps, advantageous) as an admirable procedure, not only for hard stones, say of about two ounces in weight and upward, as a rough general estimate, but also for smaller ones in some cases where the urethra was not large, or other circumstances seemed to indicate it. Further, he could not doubt that many men whose experience was necessarily small would cut for a hard stone weighing an ounce more safely than they would crush it at a single sitting. Great and irretrievable damage might be easily inflicted, by large lithotrites and evacuators in unpracticed hands. For two, among the forty-eight cases of lithotrity recently operated on multiple sittings were preferred, for the reasons given; and he strongly advised the exercise of an independent judgment in every case, and not the pursuit of any routine method, without reference to the very varied circumstances which calculous disease largely presented.

A paper was also read by Herbert W. Page, M.C., F.R.C.S., on

The Immediate Suture of Divided Nerves.

The author referred to the readiness with which divided nerves united if circumstances were favorable for the correct apposition of the ends, as in clean cut wounds, or where section had been made for the relief of neuralgia, too often frustrated by the reunion of the nerve. In jagged and lacerated wounds, where the conditions were altogether different, and where the soft parts were separated from one another, it was unusual to meet with reunion of divided nerves, whose ends had probably been wide apart. Such cases gave a history rather of neuralgia, and trophic disturbances than of regained functions and restored usefulness of limb. Success had frequently attended the operation of secondary section of nerves, as in cases of Mr. Hulke, von Langenbeck, and others referred to in the paper, which showed the desirability of primary section in all cases of divided nerve-trunks in lacerated wounds. The recorded cases of primary nerve-section were few in number; and the author, after alluding to those mentioned by Mr. Favell, in his address before the Association at Sheffield, and to those by Létiévant, in his *Traité des Sections Nerveuses*, gave the history of two successful cases of primary section of the median nerve, severed in lacerated wounds of the upper arm. The cases, one under the care of Mr. Walter Pye, and one more recently in St. Mary's Hospital, under the care of the author, were recorded in detail. Although for all practical purposes the function of the nerves had been regained, and the usefulness of the limbs thereby preserved, there had not been perfect restoration of sensation; and the author doubted whether, in face of the improbability of each and all of the divided fibres becoming once again accurately continuous in the nerve-trunk, there could ever be so perfect a restoration as would bring back sensation to the state in which it was before injury. The material used for suture, whether silk, silver, or catgut (with a preference in favor of the last), or whether it was desirable to pass the suture through the nerve-trunk as well as through the neurilemma, were matters of less importance than the avoidance of suppuration. Suppuration evidently prevented reunion in some of the cases mentioned in the paper; and the author concluded that in nerve-section the absence of suppuration, and the method of repair accompanying it, were of the greatest moment. These could only disturb early efforts toward union, involve the nerve-ends in an irregular cicatrix, and lead thereby to the neuralgia and trophic derangements which together made a useless limb. To the absence of suppuration in the healing of the very severe wound in his own case the author attributed in great measure the successful issue of the immediate suture of the widely separated ends of the nerve.

In a paper by Dr. Austin Meldon, on

Intravenous Injection of Milk,

the author stated that he had performed the operation twenty times, twelve of these being in cases of phthisis, in which the patient had reached an almost moribund condition. The author stated that he was somewhat disappointed as to the very temporary nature of the improvement which followed the operation in these cases, four of them having since died. He was, however, satisfied that life could be prolonged in phthisis by the operation; but when delayed, as in these cases, until the last stage, little further benefit could be expected. Four of the operations were in cases of pernicious anæmia, all of which, the author believed, were cured by the operation. Two were cases of exhaustion from hemorrhage, both of which recovered. The remaining two were cases of exhaustion after typhoid fever, in both of which much benefit followed the operation. The patient in one of them, however, died after the second operation. In conclusion, Dr. Meldon stated that he believed intravenous injection of milk to be a far better operation than the transfusion of blood. It was much more satisfactory in its results, and quite devoid of the dangers of the latter operation. He invariably used goat's milk, as the animal was easily procured in Dublin, and could be brought into the chamber of the patient—thus avoiding any delay in the transfusion after milking. He never used more than six ounces at a time, and always took care that the milk was alkaline, by adding a little carbonate of ammonia to each injection.

[*To be continued.*]

Editorial Department.

Periscope.

A Successful Case of Transfusion of Blood.

The following case, which exhibits in a marked degree the beneficial effects of transfusion of blood when performed in cases of impending death from excessive hemorrhage, is reported in the New York *Medical Journal*, for August, 1880, by Joseph W. Howe, M.D.:—

Mrs. B., aged twenty-two years, was delivered of a three months' fœtus, November 7th, 1879. From that date until November 11th she had repeated and profuse hemorrhages from the uterus. On the 10th the bleeding was continuous. Drs. Reynolds and Comstock, who were first called in, succeeded in controlling the hemorrhage, but not before the patient had reached the stage of collapse. They remained with her all night, endeavoring, with the ordinary means of stimulation, to rouse her, but without avail She continued to sink in spite of everything.

On the morning of the 11th I was sent for. The patient was then completely pulseless and

partially unconscious. The extremities were cold and clammy, and it was evident that unless some fresh blood were introduced death would soon supervene. She was so far gone, that I made up my mind not to spend any time in defibrinating the blood. I opened the median basilic vein in the right arm of the patient, and introduced the closed cannula of Colin's instrument, and after passing some warm water through the cylinder of the instrument, attached it to the cannula in the patient's arm. The median cephalic vein in the right arm of the donor was then opened, and the blood was allowed to flow directly into the cylinder without defibrination. When a sufficient quantity had been obtained, and while the blood was still flowing, I injected, without any difficulty, between seven and eight ounces. The whole operation did not occupy more than five minutes in its performance.

Within half an hour the pulse returned at the wrist, the voice became clear and distinct, and she asked for something to eat, saying that she felt stronger and better in every way. One of the medical gentlemen who had been with her all night, assisting in the attempts at resuscitation, and who left in the morning, believing that there was no hope of her recovery, came in an hour after the operation, and said it was "a perfect transformation scene"—that he had no idea that a few ounces of blood could restore lost vitality so rapidly.

From that time on the patient continued to improve, and when I last heard from her she was in the enjoyment of good health and attending to her household duties without any discomfort whatever.

The Treatment of Asthmatic Bronchitis.

Dr. A. W. Perry says, in an article on the above disease, published in the San Francisco *Western Lancet*, for September, 1880—

In regard to the treatment of the acute attacks of asthma, occurring in the course of a chronic bronchitis, we find the best treatment to provoke free diaphoresis, by the use of morphia, aconite, carbonate ammonia, quinia, variously combined. Counter-irritation over the chest is all important, and we prefer for this the use of croton oil, until free pustulation is produced; it is severe, but usually more effective than anything else. In milder attacks, mustard plasters, or turpentine stupes, repeated two or three times a day, may be used.

The treatment of the chronic bronchitis by medicines is of minor importance. Where cough is violent or frequent, it should be restrained by narcotics, and those should be selected which, though long continued, will be least likely to disorder the appetite and bowels. We prefer, therefore, Cannabis indica resin in one-sixth to one-third grain doses, sometimes combined with belladonna, hyoscyamus, hydrocyanic acid; all of these are less sure in their effects than morphia. At the same time, small doses of sulph. quin. with sulph. iron or zinc, should be used as tonics and for diminution of excessive expectoration.

Continuous but mild counter-irritation should never be omitted. The expectorants, squill, ipecac., antimony, I only mention to condemn entirely.

The asthma or dyspnœa in this disease may be a narrowing of the bronchial tubes by swelling of the mucous membrane, or a spasmodic muscular narrowing. It is usually a compound of these two conditions. The remedies useful in pure or spasmodic asthma will be found useful in this, in proportion as the nervous element predominates; chloral, five to ten grain doses every hour, cannabis indica, morphia, five-grain doses of iodide potassium, all prove highly useful. Against the inflammatory narrowing, strong counter-irritation is the most efficient.

To summarize: chronic bronchitis on the seacoast of California has only slight remissions, is frequently complicated by asthma, and rapidly and progressively increases in severity, producing emphysema, dilation of right heart, and permanent disability. The principle treatment is, to procure decided (either short or long) intermission, by residence in a warm climate; having produced these intermissions, avoid the effects of returning to cold winds and fogs by respirators, cold bathing, and the abortive treatment of commencing naso-pulmonary catarrh.

Multiple Papillary Tumors of the Labial, Buccal and Glossal Mucous Membrane.

The following report of a case by Dr. C. J. March, of Camden, Ark.. appeared in the St. Louis *Courier of Medicine and Collateral Sciences*, for September, 1880:—

Alice N., aged 9, was brought to my office June 13th, 1880, by her mother, who requested me to examine the interior of the child's mouth, "for," as she said, "there is something growing there." I complied with her request, and on inspection I found a very remarkable state of affairs. The mucous membrane of both lips, from the point where it is reflected on to the gums out to the muco-cutaneous junction, that lining both cheeks, as far back as the second molar tooth, and that covering the anterior half of the dorsum of the tongue, was studded with tumors, varying in size from that of a millet seed to that of a large pea. On the labial and buccal mucous membrane the tumors were sessile, and so thickly set that in places, they actually crowded one another. On the tongue, the papillæ were in various stages of hypertrophy, some being but slightly enlarged, while others had formed quite large pedunculated and slightly lobulated tumors. The epithelium covering the tumors presented its normal appearance The tumors manifested no tendency to hemorrhage or ulceration. It is proper to state here that the tonsils were hypertrophied also. The affection was symmetrical, there being as many tumors on one side as on the other.. The mother said that about a year before she brought the child to me she noticed two or three small growths on the mucous membrane of the lower lip; hence the spread of the affection had been quite rapid, as at the time of examination there were not less than one hundred tumors of various sizes.

The fact of the hypertrophy being symmetri-

cal might lead us to suspect a constitutional cause; but I could ascertain no history of syphilitic or other taint which might be assigned as a cause.

In the way of treatment, I gave the patient internally five grains of potassium iodide in solution, after each meal, and I directed the local application of a saturated solution of sulphate of iron three or four times daily. This treatment has been followed by a prompt disappearance of the tumors.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the September number of the *Virginia Medical Monthly* contains a treatise on *Myopia in its Various Phases*, by Julian J. Chisolm, of Baltimore, Md.

——*The Indications for Treatment in Fractures at the Elbow* is the subject of a paper by Lewis S. Pilcher, M.D., which now comes to us in the form of a reprint from the Annals of the Anatomical and Surgical Society, Vol. ii, No. 9.

——Geo. P. Rowell & Co's "American Newspaper Directory," for 1880, is a handsome volume containing a list of periodicals published in the United States and Canada. It also contains a great many advertisements of newspapers, etc. Its accuracy is not, however, equal to its typographical excellence. At Messrs. Rowell & Co's request, we sent to them, for this Directory, a sworn statement by the printer, of the regular circulation of the Reporter. Either through negligence or other reasons, possibly connected with the fact that we did not accompany it with an advertisement, this statement was suppressed and a decidedly lower one entered. We are by no means alone in impugning the accuracy of the figures given in this volume.

BOOK NOTICES.

A New School Physiology. By Richard J. Dunglison, A.M., M.D., author of "The Practitioner's Reference Book," etc. Illustrated with 117 engravings. Porter & Coates, Philadelphia. Cloth, 8vo, pp. 314.

It is with great pleasure that we recommend the volume before us to the favor of teachers and others having charge of the training of the young of both sexes, hoping that the subject of which it treats may be more universally taught in our schools in the future than it has been heretofore, and that it may, when practical, be taught by those who are competent to do so, viz., intelligent and educated physicians. Every citizen would then be to a certain extent a sanitarian, and be able to appreciate the value of hygienic measures, and there can be no doubt but that thousands of lives would annually be saved that now fall victims to preventable diseases. As a text-book for children the work is all that can be desired.

Transactions of the Indiana State Medical Society, 1880. Thirtieth Annual Session. Indianapolis. Carlon & Hollenbeck, Printers and Binders. pp. 362.

Transactions of the South Carolina Medical Association. Thirtieth Annual Session, held in Columbia, S. C., April 20th and 21st, 1880. Charleston, S. C. Edward Perry. Printer, Stationer and Bookseller. pp. 58.

The President of the Indiana State Medical Society, Dr. J. R. Weist, of Richmond, Ind., chose for his subject, "Problems in Relation to the Prevention of Disease," which he discussed in an able and thorough manner. Among the papers read, were: "The Icteric Form of Pernicious Fever," by Dr. William R. M'Mahan, of Huntingburg; "Kakonemia," by Dr. S. C. Weddington, of Jonesboro; "Ergot, its Use and Abuse," by Dr. William Commons, of Union City; "Human Longevity," by Dr. W. S. Haymond, of Indianapolis; "Expert Evidence; What is it? by Dr. F. J. Van Vorhis, of Indianapolis; "Harmony and Associated Action in Connection with State Medicine," by Dr. J. D. Gatch, of Lawrenceburgh; "Some of the Unsolved Problems of Public Hygiene and Synteretic Jurisprudence," by Dr. J. W. Hervey, of Indianapolis; "Women Physicians in Hospitals for Insane Women," by Dr. Mary F. Thomas, of Richmond; "Sanitary Survey of Indianapolis," by Dr. Thad. M. Stevens, of Indianapolis; together with many other papers and reports of cases. The volume is handsomely bound in cloth.

The South Carolina Transactions contains, besides the President's Address, by Dr. F. M. Robertson, a report by Dr. Thomas Legare, of Charleston, on "Cases of Epileptiform Convulsions Successfully Treated by Hypodermic Injections of Sulphate of Atropia;" "Report of a Case of Arsenical Poisoning, and of a Case of Morphine Poisoning, both suicides," by Dr. C. N. Shepherd, Jr.; "Report of the Executive Committee of the State Board of Health," by Dr. S. Baruch; together with letters on various subjects.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

HOW THE METRIC SYSTEM HAS BEEN GETTING ON.

A calm survey of the field during the past summer leads to the conclusion that the extraordinary dash with which the metric system rushed into the arena a year or two ago, in this country, was a false start. A certain number of youthful doctors took it up with zeal, just as they do the new remedies which are boosted every month or two; a certain number of old doctors bored themselves greatly by learning and using it, for fear they would be called old fogies by their younger competitors. Several medical journals and one or two publication committees of State societies passed decrees violently expelling those old friends the ℈, ʒ and ℥ from their pages. A huge reform was immediately to be inaugurated and carried by a sweeping vote.

A perceptible cooling off has followed within the last six months. The medical journals alluded to have quietly readmitted the banished old friends on divers occasions; and the metric doctors, young and old, are shocked to discover that their impetuous welcome to the French stranger may possibly have been misplaced, and is not likely to be shared by their compatriots in the profession.

To show the justice of this opinion, we shall quote the words of various esteemed contemporaries, which will indicate conclusively, we take it, that the tide has turned, and that we had better drop the effort to force into prescription writing the method so hotly urged upon us.

The Detroit *Lancet* has put very strongly the fact that the meter is not only an arbitrary, but a confessedly erroneous standard. It quotes with approval the expression of the eminent astronomer, John Herschel, to the effect, that the

"production of the meter was not a blunder only, it was a sin against geometrical simplicity. It was a sin, because in the earth's axis they had a straight and unvarying line."

This is a knock-down blow from an authority which it were vain to question. It puts an end to the metrical system's claim to be based on an invariable natural relation.

From the same quarter the *Michigan Medical News* speaks in equally decided terms. In its issue of August 10th, we read:—

"The advocates of the metric system are very persistent in their efforts to foist it on the profession. In season and out of season they are advocating its claims, and urging that it supplant the system of weights and measures now in use. They have succeeded in achieving for it a foothold in the coming decennial pharmacopœia—a foothold which, unless care be exercised, will result in a repetition of the camel's intrusion, in the fable. There is no objection to its employment in pharmacy, that is, for the purpose of manufacturing, but to introduce it into the dispensing of drugs will be to cause great confusion.

"The simplicity of the metric is urged. This is an illusion. It admits of but one bisection, and then a complexity begins, from which only a specially endowed mathematical mind can extricate itself, with any degree of certainty.

This last point has been well developed in the Atlanta *Medical Journal*, by Dr. C. W. Erwin. It is psychologically true, and the result of all experience, that the mind conceives more easily a quantity expressed in a few large units than in many small ones. The distinctions of coinage all recognize this. Why have dollars when one

could speak of hundreds of cents; why cents when we could speak of thousands of mills, except for this obvious reason? Dr. Ennis' remarks are as follows:—

"No system should take precedence of the old that is not, 1st, as accurate; 2d, as easily and quickly calculated; 3d, does not express weight, quantity, bulk or measure; present to the mind as rapidly and, as nearly as may be, the exact appreciation of the quantity, weight or measure expressed by the numbers.

"It is not only necessary to calculate by arithmetic the vulgar or decimal fractional part of any unit of measure, but when the answer is called, the mind should grasp the idea of the actual quantity or bulk expressed by figures.

"Now we contend that the lower the numbers, and fewer the figures, the more readily the mind takes in the idea. For this reason experience has taught us when figures expressing quantity, weight or measure become too numerous it is best to resort to lower figures of a higher denomination."

The *Western Lancet*, San Francisco, observes:—

"It is an astonishing fact, that in looking over medical literature for a year or two back, we find so few objections to the system, when it is so manifest that such a system, if adopted into our text-books, will render the reading ambiguous and tangling, unpractical and unused; subjecting the entire text-book to the caprices of an unnatural regime."

The *Medical Annals*, Albany, in the June number, set forth strongly the inaccuracy of the system, and distinctly avowed their determination not to adopt it.

The *Medical Herald*, of Louisville, calls the whole system "an absurdity," and praised the Association of Medical Editors that they had declined to recommend it.

Meanwhile the American Medical Association, at its late meeting, recommended the adoption of this system, and is endeavoring to force its adoption by medical colleges, medical and pharmaceutical institutions and by medical men. Its Committee is to report all medical colleges who do not adopt it.

Of this action Dr. Gaillard writes, in his *Medical Journal*—

"The whole effort will be an absolute failure. Nothing less than a law making its adoption imperative by the representatives of all avocations using weights and measures can secure its use by physicians. It is idle to use resolutions and reports for this purpose. It is courting failure."

This inconsiderate action of the American Medical Association has very naturally developed opposition. It is rather too much to have an awkward and erroneous system thus crammed down the throats of the profession, will they, nill they. This opposition has crystallized itself into the form of an "International Institute for Preserving and Perfecting Weights and Measures." Branches of this Society have been organized in Boston, Cleveland, Pittsburg, and elsewhere. Charles Latimer, of Cleveland, has written a pamphlet on "The French Metric System," published by Thos. Wilson, 188 Monroe street, Chicago, which claims to show that the time and place of the French Revolution and the worship of the Goddess of Reason did not produce a metric system worthy of adoption by the world.

For our own part, we have, as readers will remember, never advocated the forcible introduction of the metric system into prescription writing. Societies and journals travel widely beyond their proper spheres in trying to force their members and correspondents to use it. It is at best of questionable accuracy; it is more likely to lead to errors in compounding; it is less rational than the present method, and it is more difficult to comprehend and use. Its only real advantage is its decimal notation, and we can get that without resorting to it.

Notes and Comments.

Therapeutical Notes.

EUONYMIN IN THE TREATMENT OF PSEUDO-MEMBRANOUS COLITIS.

According to *la France Médicale*, Dr. Blondeau brought before the Société de Therapeutique, recently, a case in which he had employed euonymin in one of his patients suffering from pseudo-membranous colitis which had been vainly treated by the most energetic remedies. He prescribed euonymin, 0.05 gram, (grain ¾), extract of hyoscyamus, 0.10 gram, (grain 1½), made into two pills, one to be taken morning and evening. After six days of this treatment the patient had regular motions and recovered her health, which she had lost for some months.

CAYMAN'S OIL AND TURTLE OIL AS SUBSTITUTES FOR COD-LIVER OIL IN CONSUMPTION.

Dr. A. C. Heffenger, Passed Assistant Surgeon, U. S. Navy, in a communication to the

Boston *Medical and Surgical Journal*, September 23d, 1880, states that in northern Peru, especially in the Chira valley, the oil from the *crocodilus palpebrosus* and *crocodilus trigonatus*, as obtained directly from the reptile, is used freely in consumption and cachexiæ, with most satisfactory results. It has almost entirely superseded cod-liver oil, being thought more nourishing and palatable. It is given in tablespoonful doses, after meals, for long periods.

On the Island of Mauritius turtle oil has been largely used with similar success.

FORMULA FOR BURNS.

Dr. Ed. H. Travel recommends, in the *Southern Clinic* for September, 1880, the following formula as an application in burns:—

℞. Acidi carbolici (cryst.), ℥ iij
Olei olivæ opt.,
Glycerinæ.,
Aquæ fontis, āā ℥ v. M.

Sig.—Shake well before using, and keep a linen cloth saturated with the solution and applied to the burned surface.

Large Hypodermic Doses of Morphia.

The promising young practitioner who edits the Chicago *Medical Gazette* or *Review*, or whatever its present name may be, was vastly exercised last winter because a writer in this journal recommended that in certain cases half a grain to a grain of morphia should be used hypodermically. He called frantically upon us to repudiate editorially such terrible doses. What must have been his feelings on reading the article by Mr. Robert Park, in the *Practitioner*, for June, who recommends from one and a-half to four grains at a dose, hypodermically, and that of Dr. Heywood Smith, in the July number, who has injected *six grains* three times a-day with benefit! We have not noticed in the *Gazette* (or *Review*) any strictures of our English contemporary. Has not Achilles fallen asleep?

Four Years for Medical Students.

The Harvard Medical Department has planned a four years' course of study, the adoption of which is optional. "The Medical Department of the Hamline University, Minnesota," announces its adoption of a full graded course of four years.

The Chicago *Medical Journal* asks: "Will the medical press of the whole country take as much pains to notice the bold and positive stand taken by the young school in Minnesota as it has the simple declaration on the part of Harvard of an intention to do something in the future?"

Inasmuch as the "Hamline University" has not a single medical student, and its "Professors" have been and are much more interested in their private practice than in medical education, it is easy to take a stand which involves no sacrifice nor even risk. Heroism and high principles are cheap at that price.

Napheys' Therapeutics.

The steadily increasing demand for this series of therapeutical works from Great Britain is a striking testimony to its value to intelligent physicians. The English press is very decided in its favor. The *British Medical Journal*, at the close of a long review of the *Medical Therapeutics* says:—

"This is a useful and interesting book, which no one can take up without finding something he did not know before." While the *Medical Press and Circular* (London and Dublin) writes of it: "After a close scrutiny we have come to the conclusion that the thorough revision given to the seventh edition of this book has made it the most valuable work on treatment a practitioner can possibly procure. It is abreast of the latest views, and its selection of names and treatment is judicious."

It will be gratifying to the various gentlemen engaged in this revision to find their conscientious labor thus justly appreciated.

Treatment of Cystitis.

In an article upon cystitis, published in the *Dictionaire Encyclopédique*, M. Chauvel recalls the advice given by M. Diday, in the treatment of inflammation of the neck of the bladder. Drink three or four times a day an infusion of linseed mixed with pearl barley; rub into the lumbar region antimonial ointment until an eruption takes place; resist the desire to evacuate the last drops of urine, and take three times a day one of the following powders: Sugar, in powder, ℥ ss.; hyoscyamus leaves, in powder, ʒ ss.; divide into 20 powders. If the pain persisted, M. Chauvel would give every half hour a tablespoonful of an infusion of 45 grains of hyoscyamus leaves in ℥ iv. of water. In a few hours there is almost always relief. If the toxic effect of the medicine manifested itself, coffee was the antidote. In chronic cystitis the author obtained good results from the following preparation, of which about the size of a cherry stone

would be given morning and evening, in a wafer. Turpentine ʒ ss., camphor gr. xv., ext. hyoscyamus gr. iij.

Removal of Nævus.

Dr. Sigler states, in the *Pharm. Centralb.*, that nævus may be removed by means of croton oil, in the following manner: Push a number of needles through a cork, so that the points project 3 to 4 millimetres. Dip the points in croton oil, then insert them in the mole and withdraw. This is a sort of Baunscheidtismus. A scab will form upon the mole; and after it has dried up and dropped off the operation is twice more repeated.

Subcutaneous Injection of Ether in Sciatica.

Dr. Comegys, in *l' Union Médicale*, August 5th, 1880, recommends hypodermic injection of sulphuric ether for the treatment of sciatica. He cites two cases, one in detail, which he has cured by this plan. Three drops of ether are injected at intervals of twelve hours. The injection need not be a deep one; and though it causes a momentary sharp pain, it does not bring on any consecutive unpleasant effects. Dr. Comegys is inclined to think that the same injection might be successful in the case of ticdouloureux, for which Dr. Marino recommends hypodermic injection of ergotine.

The Ephelides of Pregnancy.

Newmann recommends, in *l' Union Médicale*, for these an ointment of chrysophanic acid one part, to lard forty parts, well mixed. Gently anoint the part, previously washed with soap and water; then apply a piece of linen, to prevent staining. Repeat the application three or four times at two days' interval, being careful not to touch the eyelids, and not to apply too strong an ointment on persons of delicate skin. The parts to which it is applied become red, then black; the skin desquamates, and the stain disappears. The same remedy may be used for pigmentary stains occurring independently of pregnancy.

Tasteless Cod-Liver Oil.

Dr. Peuteves, in *la France Médicale*, recommends, in order to render cod-liver oil tasteless, to mix a tablespoonful of it intimately with the yolk of an egg, add a few drops of essence of peppermint, and half a tumbler of sugared water, so as to obtain a *lait du poule*. By this means the taste and characteristic odor of the oil is entirely covered, and the patients take it without the slightest repugnance. Besides, the oil being thus rendered miscible as the water in all its proportions, is in as complete state of emulsion as the fats at the moment they penetrate the chyle vessels, consequently absorption is better assured.

Correspondence.

Consciousness.

Ed. Med. and Surg. Reporter:—

Referring to Dr. Bigelow's article in your journal, I ask: What does natural history teach about consciousness? What does common sense teach? Simply that it is a modification of sentience—just such a higher kind of sentience as every animal possesses that has a sensorium. I believe with George Henry Lewis, that sentience is a property of all organized, living matter. For proof, I need only refer the readers of this journal to the masterly treatment of this subject in the last three volumes of Problems of Life and Mind, works which are as much the delight of the physician, as they are the bane of the metaphysician. That, moreover, there is a regular gradation, in correspondence with nervous evolution, from sentience of the simplest kind as seen in the undifferentiated protozoon, to the complex and coördinated forms of sentience seen especially in the higher mammalia. No intelligent and impartial observer can doubt for a moment that dumb animals possess consciousness; and this, as the product of laws and conditions of the same kind as have given rise to consciousness in man. *If consciousness in man be due to any principle independent of organization, it must be the same in the lower animals.* To this postulate sagacious thinkers in all ages have given their assent. (Vide Jos. Cook's Biology. Cook sees and confesses the stern logic of the claim.)

Under what *special* conditions has consciousness arisen in the animal kingdom? There is, I think, sufficient reason to believe in a growing seriality in psychical changes, necessitated by advance of the correspondence between the organism and its environment. In short, severely as has been criticised a celebrated passage in Herbert Spencer's Psychology, I think that we have here the "last word" of explanation.

"How only can the constituent changes of any complex correspondence be coördinated? Those abilities which an intelligent creature possesses, of recognizing diverse external objects, and of adjusting its actions to composite phenomena of various kinds, imply a power of combining many separate impressions. These separate impressions are received by the senses, by different parts of the body. If they go no further than the places at which they are received, they are useless. That an effectual adjustment may be made, they must be all brought into relation with one another.

But this implies some centre of communication common to them all, through which they severally pass; and as they cannot pass through it simultaneously, they must pass through it in succession. So that as the external phenomena responded to become greater in number and more complicated in kind, the variety and rapidity of the changes to which this common centre of communication is subject must increase; there must result an unbroken series of these changes, there must arise a consciousness. Hence the progress of the correspondence between the organism and environment necessitates a gradual reduction of the sensorial changes to a succession, and by so doing evolves a distinct consciousness, a consciousness that becomes higher as the succession becomes more rapid, and the correspondence more complete."—*Psychology*, vol. 1, p. 403.

With this Spencerian explanation of consciousness, as objectively a succession of sensorial changes, I fully agree. E. P. HURD, M.D.

Newburyport, Mass.

[We have received several other letters on Dr. Bigelow's article, to which we can hardly give space, particularly as the above presents the familiar scientific explanation of consciousness. It should not pass unnoticed, however, that some of the most eminent naturalists find Spencer's explanation incomplete, as, for example, Prof. E. D. Cope. This distinguished scientist, in the course of a review of Prof. Barker's Address at the last meeting of the American Association for the Advancement of Science, says, in the October number of the *American Naturalist*—

"We note here, that Prof. Barker has not touched on the question of consciousness in his address, and it might be supposed that he does not regard it as an essential element in the problem. This omission may be explained on the supposition that he does not know what to do with it; for it certainly does not seem to have any appropriate niche in the system of the purely physico-vitalists. For our own part we cannot escape it in considering the evolution of forms; that is as modifying growth nutrition, through molar movements."

Evidently the inquiry into consciousness from a purely scientific side has by no means touched its conclusion. ED. MED. AND SURG. REP.]

NEWS AND MISCELLANY.

The Two Bogus Colleges Finally Wiped Out.

The American University of Philadelphia and the Eclectic Medical College of Pennsylvania, known to the community as Buchanan's Colleges, were, on September 30th, finally wiped out of existence. J. Howard Gendell, who represented the Commonwealth of Pennsylvania, filed his replication to the answers, put in by the colleges some time ago, to the quo warranto proceedings against them. The answers of these two corporations were, that they had a right to exercise their franchises by acts of the Legislature. Mr. Gendell's replication set out substantially that the colleges forfeited their rights under those acts, because they conferred degrees upon persons not possessing the qualifications prescribed in their charter; by selling diplomas; by granting degrees for doctor of medicine and antedating the diplomas so as to make it appear that the party had a right to practice medicine; and finally, by issuing diplomas with forged signatures. After the replication was filed the counsel for Dr. Buchanan confessed judgment of ouster, and filed, as part of the record, a letter from Dr. Buchanan instructing him to do so.

Leprosy in the Sandwich Islands.

The *British Medical Journal* informs us that, according to the report of the Board of Health of Honolulu, the Leper Hospital, on the island of Molokai, contained 684 patients on March 31st, 1880, three being children of lepers, and under one year of age. There were 424 males and 260 females. The greater portion of the lepers are treated as out-patients, and it is stated that a large number remain mixed with the people in the several islands. The average mortality among the lepers in the establishment at Molokai, has been nearly 58 per 1000 *per annum*. Dr. N. B. Emerson, physician to the establishment, states that, on the approach of damp and chilly weather in November, there is a general aggravation of symptoms in leprous persons, with fresh eruptions, attended with chill and fever closely resembling intermittent. Dr. Emerson concludes that, while much may be done to palliate, no curative means have yet been found in this disease. He is convinced that the disease is contagious, and states that, though first introduced into the Sandwich Islands about 1856, there are now thousands of lepers, and the disease is still rapidly increasing among the native population.

Dr. Holmes on Spelling Reform.

Dr. Oliver Wendell Holmes says, in a letter to a member of the English Spelling Reform Association—I should not care to be an obstructive (if I could be) in the way of any well organized, scholarly attempt to reform our English and American language. But you must allow a fair share of old square-toed prejudice in their personal likings to old square-toed people. I hate to see my name spelled *Homes*. yet I never pronounce the *l*. I know from old Camden that its derivation is from the word *holm*, and I want the extra letter.

The Drainage of Lands.

The *Sanitarian* recommends the following method as infallible:—

"Drink whisky and spend all your time at a village saloon. This will surely drain you of all your lands in a very short while."

Pills and Shot.

A doctor being out for a day's shooting took an errand boy to carry the game bag. Entering a field of turnips the dog pointed, and the boy, overjoyed at the prospect of his master's success, exclaimed: "Lor, master, there's a covey; if you get near 'em won't you physic 'em?" "Physic them, you young rascal, what do you mean?" said the doctor. "Why, kill 'em to be sure," replied the lad.

The American Academy of Medicine.

The Annual Meeting of the Academy was held last week, at Providence, R. I. The following named officers were elected: President, Dr. Edward T. Coswell, of Providence; Vice-Presidents, Drs. Henry Orlando Marcy, of Cambridge, Mass; William T. Taylor, of Philadelphia; Howard Pinckney, of New York City, and Horace Lathrop, of Cooperstown, New York; Secretary and Treasurer, Dr. R. J. Dunglison, of Philadelphia; Assistant Secretary, Dr. Charles McIntire, of Easton, Pennsylvania.

Preserving Rubber Instruments.

Various articles and instruments made of rubber are apt, with time, to become dry, to crack, grow brittle, and lose their elasticity. Dr. Pol recommends the following simple mixture:—Water of ammonia one part, water two parts—in which the articles should be immersed for a length of time, varying from a few minutes to one-half or one hour, until they resume their former elasticity, smoothness, and softness.

Starvation Heroes.

After all, it would seem, says the *Med. Press and Circular*, that Dr. Tanner is only a plagiarist, and four hundred years behind the time. In the church of St. Mary, at Bury St. Edmunds, is an altar tomb, surmounted by a recumbent figure of a starved man, the details of which are well executed. It was erected to the memory of John Baret, who died of starvation, in 1463, while attempting to fast forty days and forty nights.

Fevers in Rio Janeiro.

The National Board of Health is advised, from Rio de Janeiro, that during the week ending September 3d there had been two deaths from yellow fever, one from smallpox, four from typhoid fever, seven from pernicious fever, and that the total number of deaths from all causes aggregated one hundred and sixty-nine.

American Association for the Cure of Inebriates.

The Eleventh Annual Meeting of the American Association for the Cure of Inebriates will be held in the rooms of the Young Men's Association, New York City, October 20th, 1880. Commencing at 11 A.M.

T. D. CROTHERS, M D., *Secretary.*

Personal.

—At San Francisco, September 20th, Dr. Samuel P. Chalfant, found guilty of murder in the second degree, for killing Josiah S. Bacon, was sentenced to ten years' imprisonment.

—Dr. Warburg, the discoverer of Warburg's tincture, has sunk into old age and poverty. A public subscription has been opened for him.

—Dr. Simeon Denton's wedding dinner at Hancock, Illinios, was eaten by over thirty guests, and immediately afterwards nearly all of them were taken violently ill. Somebody had abstracted some poison from the Doctor's stock of drugs, and put it into the wine.

—Dr. William Williams, of Somerset county, Me., died a few days ago, from the infirmities of old age, being in his eighty-fifth year. For a number of years Dr. Williams represented Somerset county in the State Legislature and was president of the Senate one session. At one time Dr. Williams owned over one hundred slaves and a large landed estate.

—Dr. Antoine Racinet, Deputy for Cotes du Nord, France, is dead, aged ninety-six years. He was the oldest of the French Legislators, and was probably the oldest physician in France, he being born January 1st, 1785, serving as a soldier in the armies of Napoleon.

—Newspapers are discussing the subject of the connection of the malarial diseases with the mental characteristics of the victims. A student of Shakspeare has said that as the great dramatist was bred in an atmosphere filled with malaria, he created "Iagos," "Hamlets," and "Macbeths.

QUERIES AND REPLIES.

Dr. C. E. O., of Miss., writes:—

Will you please inform me, through the REPORTER, whether or not *cancer* is inoculable. Is it safe to use a speculum on a sound woman that has been previously used on one suffering from carcinoma uteri.

Ans.—Most histologists hold that carcinomatous matter may be conveyed from one person to another, and as long as there is the least doubt on the subject, it would be improper to use any instrument which had been previously used on a patient suffering with cancer without the most thorough cleaning.

MARRIAGE.

BARDWELL—McKINNEY.—In Emporium, Pa., Sept. 22d, 1880, at the residence of the bride's brother, by the Rev. H. Q. Miller, Rector of Emmanuel Church, E. O. Bardwell, M. D., of Emporium, and Miss Margaret McKinney, of Cincinnati, O., daughter of Isaac McKinney, M. D., of Jersey Shore, and niece of W. H. Woods, Esq., of Cincinnati. No cards.

DEATH.

GRUMBINE.—At Mt. Zion, Lebanon Co., Pa., on the 21st of September, of typhoid fever, Annie E. Grumbine, wife of Dr. Ezra Grumbine, and daughter of Dr. D.H. Beaver, of Fredericksburg, Pa., aged thirty-one years, eight months and eight days.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1233.] PHILADELPHIA, OCTOBER 16, 1880. [Vol. XLIII.—No. 16.

Original Department.

~~Lecture~~.

PRESERVATION OF THE MALAR BONE IN ~~operations on~~ THE ~~antrum~~.

~~Lecture from a Lecture~~ by Prof. W. H. Pancoast, ~~at the~~ Philadelphia Hospital.

~~Reported by George Friebis, M.D.~~

The ~~next~~ patient ~~brought before the class~~ was a young lady, fourteen years of age, Miss Mamie Alexander. The right cheek was very much swollen, so as to nearly close the right eye. Prof. Pancoast let the class see the face as she walked around the arena, and then, opening gently her mouth, pointed out how the whole right upper jaw seemed involved in the swelling, the roof of the mouth pushed downward, and the swelling extending to the suture of the horizontal processes of the superior maxillary, and palate bones. The skin of the cheek was tightly stretched, and as the lecturer gently lifted up the cheek and the corner of the mouth, the rounded tumor could be seen, showing how the outer wall of the antrum of Highmore was pushed out. The first molar had been already drawn before he saw her, and a probe was inserted through its socket into the antrum. The probe end moved with difficulty, meeting with resistance, demonstrating that the tumor involved the cavity of the antrum. The lecturer stated that the patient had been a week under his care, receiving tonic treatment; that he liked always to prepare his patient beforehand for an operation, to regulate the secretions, and have the sufferer in the best condition possible to support the shock of an operation and its consequences. The tumor was considered to be a sarcoma, apt to return, and required a very thorough removal. The patient believed the tumor to be the result of a blow upon the cheek, from a ball, received some months past.

For the successful extirpation of the tumor, the lecturer said it would be necessary to remove the whole upper jaw. The operation is a serious one, and must be carefully performed, to avoid hemorrhage from the internal maxillary artery, or its branches. If bleeding should occur, ligate the bleeding vessels, if possible, in the wound, and it is well not to close the wound immediately, so as to avoid secondary hemorrhage. If secondary hemorrhage should occur, it is better to tie the external carotid artery in the middle triangle of the neck, than to reopen the face and give an additional shock to the patient; and even before closing the wound, if the hemorrhage cannot be successfully controlled, it may become necessary to ligate the external carotid. In the five cases of exsection of the upper jaw that Prof. Pancoast had performed, he said he had secondary hemorrhage in only one. The patient was a gentleman from Kentucky, who had violent hemorrhages from the tumor previous to the operation. The blood flowed freely from the mouth and the nose, and twice his life was in great danger. The wound was not closed for about four hours, but hemorrhage recommenced, flowing mostly from the mouth, and at midnight the lecturer was obliged to ligate the external carotid artery in the middle triangle, successfully checking the bleeding. The lecturer spoke of another case where he removed the left superior maxillary bone, for sarcoma, in a lady seven months gone with pregnancy. The tumor was growing so rapidly that he feared it would kill the patient before she

came to term, yet he dreaded that the shock of an operation might produce an abortion. He induced the patient to consult Prof. Gross and Emeritus Prof. Pancoast. They also feared that an abortion might be the result of the shock, but believed the operation was justifiable. Prof. Pancoast said he performed the operation, and it was not followed by any untoward symptom. The operation was performed under ether, and the deep parts of the wound were seared with the hot iron. No uterine pains occurred, no suppositories of opium were required. The wound healed quickly and completely in ten days, when the patient was discharged from treatment and went home. The lady went her full time and was delivered of a healthy boy.

Prof. Pancoast now showed the class a skull, and pointed out the articulation of the superior maxillary bone with the other bones. How it is fastened posteriorly to the horizontal and vertical plate of the palate bone; at the inner side of the orbit, by its nasal process, to the frontal bone and the os unguis; on the outside by its frontal process, to the frontal bone; and also by a broad one to the malar bone. By this method of articulation the force which is used by the lower jaw upon the upper, in mastication, is not expended upon the upper maxillary bone, but is distributed by these processes all over the egg-shaped skull. In mastication, as you know, it is not the upper jaw that moves, but the lower, the lower acting on the upper as a hammer upon an anvil. It is necessary to understand this anatomical construction, to properly comprehend the operation. In consequence of these attachments of the upper maxillary, the disarticulation of the bone has been accompanied with that of the malar bone; the chisel and hammer, or the long cutting forceps, being applied first upon the nasal process of the bone, then to the external or frontal process, and then to the thin zygomatic process of the malar, at its junction with the zygomatic process of the temporal. The bone is then cut from its fellow, pried down from the orbit, cutting with curved scissors, or the chisel, the superior maxillary nerve, where it enters the infra-orbital canal. Prying still further, or pulling with strong forceps, the bone is separated from, or brings with it a portion of the palate bone, and the exsection is finished.

Years ago, in demonstrating this anatomy, I was always struck with the solidity of the malar bone, in contrast with the other bones of the face. This is a practical anatomical point, showing the evidence of design in forming the skeleton. As the malar bone is the prominent bone, making the support of the cheek, and exposed to blows, it is necessary and well that it should be a solid bone, well buttressed to the skull. If it were spongy, it might still support the cheek, but it would be frequently liable to fracture, and also to inflammation and caries. Again, I noticed in the operation in which it was removed, that, while the superior maxillary was a mere sponge, so broken down was it, yet the malar was solid and apparently unaffected by the disease.

In my second operation, for the removal of the superior maxillary bone, for cancer, I decided that my patient should have the benefit of my observations. I had a big curved needle made, fashioning it on the skull so that it would readily pass through the anterior fissure, in the floor of the orbit, and present readily in the mouth, so that the ligature it carried could pull a chain saw easily through. This is the needle I show you. With the chain saw I readily severed the articulation of the superior maxillary from the malar. It takes but a little more time to do so, and the consequent gain of less disfigurement from the operation, by retaining the malar bone, is great, and not only pleasing to the operator, but very gratifying to the patient.

As the young patient was now etherized, the lecturer proceeded with the operation, first pointing out the position of the parotid duct, shown by a line drawn from the lobe of the ear to a point midway between the ala of the nose and the angle of the mouth, the duct emptying into the mouth opposite the second bicuspid tooth of the upper jaw.

The operator chose a medium-sized well balanced scalpel, two tenacula black silk ligatures, some fine and some very strong, dissecting forceps, a good, strong pair of cutting forceps, and the curved needle armed with a ligature tied to a chain saw.

The patient was placed upright in a chair, so that the blood would flow readily out of the mouth, and not down the throat.

The knife was entered deeply, a half inch behind the external angular process of the frontal bone, and the incision swept down vertically and rapidly to the line of Steno's duct, then parallel with and above the duct, to the right ala of the nose, and then down vertically, completely through the upper lip, just in front of the angle of the mouth. The flaps were turned off the bones with careful and rapid touches of the knife, a coronary artery tied with a black silk ligature, the facial artery caught and held by a pair of arterial forceps, which were left hanging to it. The large curved needle was passed under

the eyeball, on the floor of the orbit, and appeared in the buccal cavity; the chain saw followed it in a moment; the bone was sawed through, separating the superior maxillary bone from the malar. With the large cutting forceps, the nasal process of the bone was cut through, the right incisor tooth was pulled out, and the cutting forceps applied to the roof of the mouth, cutting through the hard palate. With his left hand the operator depressed the bone, and with a pair of curved scissors cut through the superior maxillary bone, separated the soft parts, and removed completely the superior maxillary bone, or remains of it, broken down and mixed with the cancerous mass, making the tumor.

The operation was over within five minutes.

The lecturer now cleaned out the wound, tearing away and cutting off with curved scissors masses which he deemed unhealthy. The arterial forceps was removed, and a black silk ligature was applied on the artery. No other bleeding, except a slight ooze, existed. The wound was carefully examined by the operator and Dr. Janney and Dr. Welsh, who were present.

The wound was pronounced healthy looking, and the tumor considered to be thoroughly removed, by these gentlemen. The cavity was now filled with strips of patent lint soaked in aqua Pagliara in such a way as to leave the ends easily accessible, and the wound closed temporarily. The operator stated that this line of incision was original with him, as well as his method of leaving the malar bone. He has seen them nowhere mentioned, though as there is so little new, probably some other surgeon may also have thought of them.

The operator said he preferred this line of incision, this sweeping, curved incision, as it left as little deformity as possible. The paralysis of the face would become less when the divided nerves united, and this form of incision permitted the flaps to be very accurately united. He also stated that the excision of the superior maxillary bone, together with the malar, is said to have been first performed in France, by Gensoul, and in England, by Lizars. Gensoul's line of operation makes an upper and a lower flap, and the description is not simple. Lizars made a triangular flap, one incision extending down vertically through the nose and the upper lip. Cutting through the nostril is not necessary, and is an additional disfigurement. Fergusson made a V-shaped flap. Warren, Velpeau, Professor Gross and others prefer a semilunar flap. The incision extends from near the zygomatic process of the malar, in a curvilinear direction, to the angle of the mouth. The one just performed more certainly avoids Steno's duct, and, the operator thought, injures fewer branches of the portic dura.

Some three to four hours after the clinic was over, and the patient had thoroughly reacted, the temporary dressing was removed, the flaps opened, the lint withdrawn and the wound found dry. No subsequent hemorrhage had occurred. The wound was examined carefully, and looked healthy, clean and dry. Lint soaked in the aqua Pagliara was again gently introduced, for astringent effect and support to the flaps. These were then neatly and carefully drawn together by interrupted black silk sutures, angle to angle, curve to curve. Only three steel toilet pins were used, one at the upper angle of the wound, one at the ala of the nose, and one through the lip, with oval suture. The incision was closely and completely united, great care being taken to unite the mucous membrane of the lip neatly and accurately. Then very fine black silk sutures were applied on the inside also, the lip being everted during the sewing, and the mucous membrane of the inside as neatly united as on the outside. The operator closed the wound up thus perfectly, to favor union by first intention, as the drainage was free, by the mouth. The line of incision externally was carefully covered by patent lint, saturated with carbolized oil, retained by two broad strips of adhesive plaster. The cheek was ordered to be covered with a solution of lead water and laudanum, and the eye with a weak solution of sulphate of zinc. A hypodermic injection of one-third of a grain of sulphate of morphia was given, and the patient, in a very good condition after such a serious operation, was placed in bed.

NOTE.—Two weeks after the operation the patient walked into the amphitheatre, looking well and cheerful. The sutures had all been removed. The wound was thoroughly united and there was remarkably little deformity. Some suspicious points were removed with scissors and touched with crystals of chloride of zinc.

COMMUNICATIONS.

THE COLUMBIA HOSPITAL FOR WOMEN, WASHINGTON, D. C.

BY HORATIO R. BIGELOW, M.D.

Incorporated by an especial Act, and largely sustained by Congressional appropriations, the Columbia Hospital, having no financial drawbacks, not only grows in popular favor, but is rapidly assuming its place among the foremost institutions of its kind in the United States.

The excellent results attending the operations are largely due to the perfect arrangements of the Hospital itself, as well as to the skill and patient watching of the surgeon in charge, assisted by the advisory board. Out of three hundred and fifty-one consecutive deliveries, there has been but a single death, and this was due to a chronic diarrhœa in a woman suffering with phthisis. So favorable a showing is not to be found in the records of any other maternity hospital that I know of, and is worthy of consideration. The hospital is under the immediate charge of Dr. P. J. Murphy, a gynæcologist of rare ability, assisted by an advisory board, composed of the following gentlemen, each one of whom is distinguished in some especial branch of medicine or surgery. Dr. J. A. Ritchie, President; Dr. Z. T. Sowers, Secretary; Drs. I. O. Stanton, L. Mackall, Jr., J. T. Young, H. C. Garrow, Robert Reyburn and D. R. Hagner. No capital operation is ever performed without a full consultation of the advisory board. From the advance sheets of the annual report for the year ending June 30th, 1880, I am enabled to give the following notes of operations and general practice.

Obstetrics.—Maternal mortality, 1. Infantile mortality, 8. Cases of twins, 3. Forceps deliveries, 8. Adherent placentæ, 2. Post-partum hemorrhage, 3. Ante-partum convulsions, 1. Ante- and post-partum convulsions, 1. Prolapsus funis, 1. Breech presentation, 9. Footling, 1. Molar pregnancy, 1. Hydramnios, 1. Still births, 6. Abortions, 7.

Causes of Death.—Maternal: chronic diarrhœa, one. The infantile deaths were from atelectasis pulmonum, premature delivery, congenital syphilis and inanition. Of the still births, one was due to asphyxia in protracted labor; one to ante-partum convulsions; three were syphilitic and premature at four, seven and a half, and eight months respectively; and one, at full term, was advanced in decomposition, supposed to be syphilitic. Of the abortions, two were at five and seven and a half months respectively, and supposed to be criminal; one was at the sixth month and syphilitic; and four were at three, four and a half, five and six months respectively, causes unknown. *In one case of twins, a dead fœtus of about four months was delivered with a living child advanced to the eighth month of gestation.*

Operations.—Adenoma mammæ, 1. Amputation of cervix uteri, 1. Enucleation fibroids uteri, 1. Enucleation fibroma cervicis uteri, 1. Femoral hernia, 1. Fistula in ano, 1. Laceration cervicis uteri, 4. Mammary abscess, 1. Ovarian tumor, 1. Polypus uteri, 1. Recto-vaginal fistula, 2. Rupture perineum, primary 5; secondary 3. Scirrhus mammæ, 2. Tumor from posterior vaginal wall, 1.

Dysmenorrhœa (membranous).—The pain is relieved by suppositories of cannabis indica ($\frac{1}{8}$ grain of the solid extract) or of the extract of conium. These suppositories are also used to allay the pain and inflammation after operations around the vagina. A solution of chromic acid—one hundred grains to the ounce of water—is passed through the cervix to the fundus, by means of the applicator.

Amenorrhœa.—The treatment is general and local. The general treatment consists, for the most part, in the use of the following pills, which are very efficacious:

℞. Ferri. sulph. exsiccat., gr. xij.
Quiniæ sulph., gr. xxiv
Ext. aloes socot., gr. iij.
Ext. hyoscyami, gr. vj. M.
Et div. in pilulæ, no. xij.

Sig.—One an hour after eating.

If the aloes disturb the bowels, the pills may be omitted for a few days, and resumed if necessary.

Menorrhagia and *metrorrhagia*, occurring without some foreign growth in the uterus, generally depend, either upon a condition of subinvolution of the uterus, or upon a fungoid state of the cervical or uterine canal, and the treatment varies accordingly. Sometimes a small polypus springing from the mucous membrane of the uterine canal is brought into view, by giving thirty minims of Squibb's fluid extract of ergot, three or four times a day, which can be removed when the condition is discovered. Treatment of the fungoid condition will be noticed hereafter.

Endometritis.—In endometritis and cervicitis, where much congestion exists, a drachm or two of blood is drawn from the cervix uteri, by puncturing it. Application is made to the canal—the applicator being carried well up—of the following:—

℞. Acidi carbolici (pur.), ℥j.
Tinct. iodini co., ℥vij. M.

The retroversion which is apt to exist in such cases is overcome by means of a modified Smith pessary. For the vesical tenesmus the copaiba mixture has given great satisfaction:—

℞. Bals. copaibæ,
Spts. ætheris nit.,
Spts. lavandulæ co.,
Liq. calcis, āā M.

Sig.—Teaspoonful four or five times a day.

As an alterative, the muriate of ammonia or the

iodide of potassium may be given. If anæmia be present, the usual practice is to prescribe the iodide of iron in full doses.

Fungoid Conditions of the Endometrium.—The membrane is scraped with a Thomas' curette, and fuming nitric acid is then applied. Dr. Murphy says that he has frequently seen such cases treated with silver nitrate, and that stenosis of the cervical canal very generally resulted. He has never seen any ill results follow the use of nitric acid or chromic acid (100 gr. to 1 oz. of water). In offensive discharges from the vagina, following either specific vaginitis or ulceration of the lining membrane of the uterus or cervical canal, and especially in offensive lochial discharges, the following solution serves a good purpose:—

℞. Pot. permanganatis, ℥j
Pot. chloratis, ℥iij. M.
One powder.

Sig.—Dissolve in a quart of warm water. Then add a teacupful to a quart of tepid water nd use as an injection.

This will control the fetor and arrest the ulcerative process going on in the vagina or external portion of the cervix.

Ulcerations are treated with the chromic acid solution already mentioned. Dr. Murphy says that he has seldom found such a thing as ulceration unless following parturition. There is usually nothing but a loss of epithelium covering the cervix and extending into the canal, unless such ulceration be produced by syphilitic virus.

Puerperal Fever.—Isolated cottages, for the accommodation of ten patients, are in process of erection, which will be used in cases of blood poisoning. This disease has been treated with marvelous success by injecting into the uterus, through a double canula, the solution of carbolic acid and iodine mentioned under the head of endometritis, using from thirty to fifty drops to a pint of water at one time, giving from fifteen to twenty grains of quinine as occasion may demand.

Post-partum hemorrhage is controlled by injections of hot water, or preferably of hot vinegar, which has sufficed in every instance.

Mammitis.—This has been arrested in almost every case by the application of *iced* cloths to the breast when the symptoms are first discovered. The method of applying the cloths is of the greatest importance. Three or four thicknesses of ordinary muslin are to be wrung out of ice water, as dry as possible; this is to be covered with oil silk or thin rubber, followed by the application of the suspensory bandage sufficiently tight to make firm compression without interfering with respiration.

Ovariotomy.—Of the six cases operated upon there has been but one death. This occurred on the tenth day, and was due to congestion of the lungs. The treatment of the pedicle and the application of Listerism are the points worthy of attention. The intra-peritoneal method has always been followed with the most gratifying results. It is in keeping with the common-sense way of dealing with large wounds; for the less complicated a method is, the better is the subsequent condition of the patient. When the pedicle is returned into the abdominal cavity, especially when the plan of Lister is carried out accurately and carefully, all the dangers which are to be feared either by clamp or cautery are averted. Chinese silk has always been used to ligate the pedicle, which ligation is performed by transfixing the pedicle and tying it in two parts, if it be not wide, and in several parts if it be unusually broad.

In the last case operated upon, May, 1880, the temperature of the patient never went above 100°, and in two weeks following the operation she was out of bed. The bloody, serous discharge from the drainage tube, which is always placed in the lower angle of the incision, never gave out the faintest odor, though sixteen ounces of it were collected. No opiates were required. For the first three days the diet consisted of milk, with an occasional small quantity of brandy, and thereafter was varied to suit the taste of the patient. The bowels moved of their own accord on the third day, and no disturbance followed.

Dispensary Practice.—Between one thousand and fifteen hundred patients are treated at the dispensary every year, the medical service being voluntarily given by the different members of the Advisory Board, assisted by Dr. Murphy. A favorite prescription of Dr. Young for chronic bronchitis and chronic phthisis has been—

℞. Ext. cannabis indicæ, fl.,
Alcoholis, āā ℥j
Syrupi acteæ co.,
Syrupi pruni virg., āā ℥vij. M.

Sig.—A teaspoonful every four hours.

Sixteen minims of dilute hydrocyanic acid may be added, at the discretion of the physician. In purulent ophthalmia the usual formula is the salicylate of soda, ten grains, pure water, one ounce. This is to be dropped into the eyes every three hours, after cleansing them with the douche. In dyspepsia, especially in that form

of it which is attended with vomiting in pregnant women, Dr. Sowers has used with the greatest success ten-grain doses every two hours, of Warner's ingluvin. The most severe cases seem to yield under its administration.

The successful working of the hospital has been largely due, I take it, to the harmonious relationship existing between the surgeon in charge, his advisory board, and the committee of management. Opinions are interchanged, a courteous deference is given by a majority to the expression of the minority, and a sense of his responsibility seems to actuate each member of the staff in the discharge of his duties. Washington has a great and constantly enlarging need of just such a charity, and the Columbia Hospital is meeting the emergency as fast as its means will permit.

Hospital Reports.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

CLINICAL LECTURE BY DR. JACOBI.

Reported for the Medical and Surgical Reporter.

Pharyngeal Catarrh.

The first case brought into the clinic was a little girl ten years old.

What is the matter with you? "I have a bad cough." When do you cough most? "In the daytime." Do you sleep well at night? "Yes, sir." What time of day does your cough trouble you most? "In the morning when I wake up."

She coughs most during the daytime, she says. The trouble is not, therefore, dependent on bronchial or pulmonary mischief, for if that were so she would be compelled to cough at night, on account of the accumulation of mucus in the tubes. She says she coughs most when she wakes up in the morning. This cough, therefore, must be the result of some accumulation during the night, taking effect in the morning, compelling her to get rid of it then. It cannot be an accumulation of mucus in the larynx, for it is not possible that the larynx would tolerate any accumulation without the resulting irritation setting up such a cough as to wake her.

This mucus collects in the pharynx, and this cough is of pharyngeal origin. When you have a history of a cough which is troublesome only in the morning, look for chronic pharyngitis. She has had this cough for two years, but there is no disease of the chest which would last as long as this and yet produce no marked constitutional symptoms, except this pharyngeal catarrh.

I have no doubt that when I examine the throat I shall find that she has enlarged tonsils also. Yes; she has two immense tonsils, deeply grooved.

The tonsil is a conglomerate of follicles which communicate with the surface by about a dozen orifices, which are the mouths of the ducts. When the mucous membrane becomes the seat of chronic inflammation and hypertrophy, there are present a number of grooves or valleys, at the bottom of which are the mouths of these ducts. The tonsil does not attain this large size, and present this general appearance, as the result of a single inflammation. She has had, perhaps, several acute inflammations and abscesses; for when you have an abscess in a tonsil, it may return again and again, because it affects a single follicle only, and as a result of successive inflammations, attain the large size which you see in this case before you. What is to be done for a case like this? Ordinarily, I should excise the tonsils at once, but at present there is a great deal of diphtheria in the city; and should I excise now, the wound might become diphtheritic, so it is better, for the present, to let operating alone. I will order the use of chlorate of potash this week, and perhaps remove the enlarged glands next week, if the circumstances are favorable.

At the same time, there is here also nasal catarrh. There is almost always nasal catarrh where there is pharyngeal catarrh. Indeed, very frequently, it is the nasal catarrh which is the cause of the pharyngeal. The best treatment for the nasal catarrh is summed up in two words —absolute cleanliness. The nose must be regularly washed out with tepid water in which a little salt has been dissolved. The solution is to be a weak one, not stronger than from a half of one per cent. to one per cent. of salt. This solution is to be snuffed up into the nostrils, until it can be spit out through the mouth. In this way a tumblerful of the solution is to be used three or four times a day. Formerly I used to use the nasal douche in this class of cases constantly, and without fear, but now I no longer resort to it; for years I have not made use of it. In forty-nine cases you may use the douche with impunity, but in the fiftieth you will have as a result otitis media, with perforation of the tympanum and perhaps deafness. This is rather a heavy price to pay for your success in the other cases. It is much better to let the patient snuff up the salt and water as I have indicated, and you may direct him to put into a tumblerful of water half a teaspoonful of salt and vary the frequency of the application, according to the severity of the case.

This constant washing out prevents the mucus from collecting in the nasal passages and getting rancid. As a rule, cases will get well in two or three months. If you wish to make use of some medicinal application, I think nitrate of silver is the best. I use it almost exclusively. Now, there is no more dangerous practice than the use of nitrate of silver in stick or in concentrated solution. There are many chronic cases which I have seen, in which the mucous membrane presents a peculiar appearance. It is shiny, hard, not moist, and thin. This condition is incurable and is the frequent result of strong solutions of nitrate of silver. Here the effect produced has been caustic, not alterative, and has resulted in a cicatricial condition in the surface to which it has been applied. Where a mild solution is used the effect is altogether different. Under the microscope the fluid may

be seen to find its way into the interior between the epithelial cells. It really changes the mor bid circulation into a healthy one. The strength of a solution to produce such an effect ought not to be more than from a quarter to two grains of the nitrate to an ounce. The same thing is true of solutions which are meant for the bladder. I must remind you of the fact that a great deal of harm can be done by the use of concentrated solutions, and never more good than by mild ones. As a rule, I use a solution of one-fifth to one-tenth per cent., that is about one-half to one grain. This I inject twice a week, seeing that it enters the pharynx properly. Then, during the intervals, let the patient attend to the salt and water washing himself.

Stronger solutions than these which I have mentioned give pain. These do not, only creating a slight uneasiness. Such a point as this seems a trifle, but it is a trifle worth remembering. Recollect, that it is by attention to trifles you will be able to cure disease. It is not the extraordinary and brilliant operations, the feats of medicine, which insure success in the treatment of disease, so much as this strict attention to trifles.

For the pharyngeal catarrh here I should use the spray. The tube I should introduce through the nose. When you do that, remember that the floor of the nasal cavity is parallel with the surface of the earth. Then, when the spray has been introduced let the patient inhale once or twice. When they feel the spray in the mouth I usually cease. Then if I look into the throat I see on the pharyngeal wall a slight, whitish discoloration, nothing more.

Imperforate Anus.

I now show you a specimen, consisting of the lower bowel, taken from a case of imperforate anus. The child in which this malformation existed died yesterday, with symptoms of obstruction, having lived only two days. There are several ways in which this malformation may occur. The anal orifice is formed in the fœtus by an invagination of the outer surface, the tube thus formed meeting and uniting with the rectum. The septum between the two tubes becomes absorbed, and the lumen of the tube is complete. Now, sometimes this septum does not become absorbed. It may exist, at the anal orifice itself, obstructing the bowel at its very entrance; or again, the anus itself may be normal, yet this septum may exist unabsorbed, some distance up the bowel, an inch or an inch and a half. Here the ends of the tubes have met and united, but the septum has not been absorbed. Again, the two tubes may not meet at all, but may be separated altogether by areolar tissue. Or again, instead of meeting end to end, they may meet sideways, and so touch only at one point. I remember operating on such a case some years ago. where the intestines touched at the side only. I put in a trocar and meconium oozed from the wound. I then put in a dilator and dilated, but in two days the child died, of peritonitis. I made a post-mortem examination, and found that because of this sidewise manner of meeting I had passed the trocar into the intestine, but also into the peritoneal cavity, into which the meconium had escaped, giving rise to fatal peritonitis; and so, although the operation rendered the canal pervious, yet it resulted fatally because of this accident.

Vesical Calculus.

The next patient is a little boy, six years old. What is the matter with him? "He has great trouble in passing water, and he wets the bed at night." Does it hurt him to pass his water? "Yes; very much; and he passes lots of blood sometimes. He strains so hard too, sometimes, that his bowels move as well."

This may mean catarrh of the bladder, coincident with stricture. That is, similar symptoms might be produced by such a state of affairs. When blood is passed with the urine, it may come either from the bladder or urethra. Should it proceed from the kidneys, the urine would have a smoky appearance, although there have been cases of renal hemorrhage where the blood has settled from the urine in the bladder, and been expelled in clots; but usually it is diffused through the whole quantity of urine, and gives it a smoky hue. In this case before you, the probable cause of the boy's trouble is stone.

What is the color of his water? "It is very dark, and has a red sediment. It looks exactly like strong tea."

Were we to see his urine, we could determine whether the blood in it were equally mixed or not. It is possible for a stone in the pelvis of the kidney or imbedded in the upper part of the ureter, to give rise to hemorrhage, which may be profuse enough to escape being mixed with the urine. I have known such a hemorrhage to prove nearly fatal. In such a case, the frequent urination and the pain in urinating may be explained by the fact that the pain is referred to the peripheral end of the nerve. In disease of the hip joint you have a similar pain in the knee, from the same cause. However, in this case I do not think that we have anything else than a stone in the bladder. I will sound him and see. We will first administer chloroform. I am going to use this silver catheter, but it is not the best instrument to search for stone. It is not at all uncommon to miss a stone with an instrument of such a curve. The best curvature for a sound which is to be used as a searcher for stone, is a right angle, and with a short end. Then you can turn it easily in every direction, and it is seldom that a stone will escape your notice.

I now pass my catheter without difficulty. I do not touch a stone anywhere. Yes; I believe I feel it there, behind my catheter, in the pouch of the bladder; and the peculiar click is quite distinct. There is a stone in the lower portion of his bladder. I shall send him to the hospital, then, and will let you know when the operation will take place, in order that you may all be present. This will end our cases for to-day.

Tri-State Medical Society.

The sixth annual meeting of the Indiana, Illinois and Kentucky Tri-State Medical Society will be held at Masonic Temple, Louisville, Ky., on Tuesday, Wednesday, Thursday and Friday, 9th, 10th, 11th and 12th, of November, 1880. Convenes Tuesday, 9th, at 9 A. M.

Medical Societies.

THE MEDICO-LEGAL SOCIETY OF PHILADELPHIA.

A meeting of physicians and druggists, called by the Committee on Medico-Pharmaceutical Abuses, acting for the Medico-Legal Society of Philadelphia, was held at the College of Pharmacy, September 24th, for mutual counsel in regard to devising some plan for correcting and advancing the interests of Medical and Pharmaceutical relations.

Mr. Wm. B. Thompson, pharmacist, was called to the chair, and Dr. R. G. Stretch was chosen Secretary.

The Medico-Legal Society was represented by Drs. Oliver, Schoales, Gruel, Stretch, Crandall, Nash, Peltz, Blackwood and Swayze.

The Pharmacists were represented by Prof. Remington of the College of Pharmacy, and Messrs. Blair, Wiley, Needles, Niskey and Evans.

The chairman of the Committee, Dr. Swayze, opened the subjects that claimed special consideration, with a comprehensive and argumentative paper on the Medical and Pharmaceutical relations, in which he spoke of the professional and pecuniary disadvantages sustained by the regular medical practitioner, growing out of the existing status and practice of pharmacy. He said that the office of the physician was to diagnose diseases and prescribe the proper remedies for their relief, while that of the pharmacist was to prepare and compound the remedies needed by the physician. But it has come to pass, that while the prescription case of the druggist is tastefully stored with remedies to *aid the* physician in the treatment of disordered health, too often the windows and counters are blockaded and bristling with pharmaceutical *hindrances or impediments* to the physician's professional and business prosperity, in the shape of advertised and money-boosted patent and proprietary nostrums for every real and imaginary ailment, by the dispensation of which the druggist virtually makes *himself* the practitioner, and assumes the treatment of diseases for which the wrappers effusively recommend them.

He also spoke of the practice of some pharmacists, of taking into their stores homœopathic specifics for general introduction and sale, and of the odium with which the medical and pharmaceutical professions have been smirched by the dirty, unscrupulous compact for percentage *divvy* on prescriptions, which merits the most prompt effacement, as being alike unfair and unjust to pharmacists and physicians in general and the confiding public in particular.

One of the most serious grievances of which he complained was the grave injustice done physicians by druggists, who, without being so authorized by the prescriber, frequently and indefinitely renew prescriptions intended by the physician for temporary employment only, and, in many instances, making them up for various persons and families other than the one for whom intended, and thus seriously hazarding the physical and moral welfare of patients and people, by the prolonged use of what was designed for but transient employment.

He also spoke of the practice of druggists prescribing for patients over the counter, which was a great injustice to the regular physician. He then concluded with the following remarks:—

We believe these are vitally important questions for the candid consideration of all pharmacists who feel with us a mutual desire to guard the honor of our alma maters, maintain an ever defensible professional integrity, and accord in practice to our fellow-laborers the charmed element of all true brotherhood, the infallible precept of the Golden Rule, "Do unto others as you would others should do unto you."

DISCUSSION.

Prof. Remington said that inasmuch as the points embraced in the paper were of great importance, he would propose that they be taken up in their order for consideration, that more definite conclusions in regard to each might be thereby reached; he therefore offered a motion to that effect, which was carried.

1st. Patent Medicines. Prof. Remington said, in his early business life he put away all patent medicine signs and medicines from sight, and thus avoided catering to the habit of displaying and selling patent medicines. Dr. Crandall was the first physician who had ever said, on coming into his drug store, "why I don't see any patent medicine or medicine signs displayed in your store!" When people inquired for these articles he sold them, but did not recommend them. He is not aware that he gets any more patronage from physicians on this account. But he believes the patent medicine business is pernicious to the public; and he was ready to join hands with physicians to exclude patent medicines.

Mr. Needles referred to the recommendation of Swayne's Panacea by a College Professor. He does not countenance the use of patent medicines; but believed physicians were sometimes responsible for their employment.

Dr. Oliver said, that Swayne's Panacea was the introduction of patent nostrums in this country; it was a long while ago that the recommendation of that Professor of the University of Pennsylvania was obtained; and the present Professors of our Medical Colleges would *not* give their names to recommendations. He feels convinced that good results have already taken place in Philadelphia as the result of the efforts of the Medico-Legal Society's proceedings. Certain druggists have already removed every patent medicine sign and put the nostrums all out of sight, and their prescription lists have more than doubled as a consequence. He referred to the case of a Cincinnati druggist who banished all patent medicines from his trade and made a fortune by legitimate pharmacy.

Dr. Crandall stated the character and objects of the Philadelphia Medico-Legal Society, and said, we want to know what agreement can be made between physicians and druggists concerning the abolition of patent medicines from the stores of all respectable pharmacists. He also interrogated Prof. Remington in regard to whether the patent medicine abuse was discountenanced by the Pharmaceutical Code of Ethics.

Prof. Remington responded that there is nothing special in the Code, but the attention of students was directed to them in lectures and valedictory addresses. There was no penalty attached by the Code to the practice of dealing in patent medicines; but instructors endeavored to inculcate proper pharmaceutical ideas.

Mr. Blair criticised some remarks made by Dr. Crandall, in regard to the increasing dissatisfaction of physicians, who had determined to move for reform in the matter of pharmaceutical abuses, and in case of failure to effect any compromise with pharmacists, would then carry their own medicines as a practicable alternative. Mr. Blair added that the remedy for the trouble was plain; let physicians patronize the druggists, and those only, who do legitimate business and drop patent medicines.

Dr. Blackwood thought we should, by committee or otherwise, see who of the druggists would put patent medicines away, neither recommend nor advertise them, and stand by legitimate pharmacy. Patent medicines harm the public much more than they do the physicians.

Professor Remington said there was evidently unanimity of feeling on the question of patent medicines, and suggested that the best way to accomplish reform would be to get druggists to agree not to sell or recommend them.

2d. Homœopathic Specifics. Professor Remington and Mr. Needles did not think druggists took them into their stores for sale to any extent. Several up-town physicians testified that a large number of druggists in the northwestern part of the city took hold of homœopathic specifics, as agents, and put up signs, two or three years ago; but the thing was dying out, through the disfavor of regular physicians.

Mr. Niskey thought physicians were much to blame for the introduction of "homœopathics," because they prescribe such disgusting mixtures for children and women, who are averse to horrid doses. Doctors were often ignorant, or indifferent to the necessity of rendering prescriptions palatable.

Mr. Blair thought most druggists are honorable, and if approached properly would refuse to sell homœopathic medicine, etc.

Professor Remington said, all things begin in an humble way, and all reforms must have a beginning. He would therefore offer the following:—

"*Resolved*, That the subjects under consideration be referred to the Philadelphia Medico-Legal Society, and that they be requested to send a committee to all respectable druggists, requesting them to place out of sight all patent medicines and discourage their sales."

He also proposed that all said druggists subscribe their names to such agreement. The motion being seconded, Professor Remington's resolution was adopted.

3d. Percentage Compact between Druggist and Doctor. Professor Remington thought it difficult to correct this evil; the druggists have no way of reaching it; if the doctors could reach it the pharmacists would be thankful.

Mr. Needles did not personally know of any such cases.

Dr. Oliver confidently assured him that this evil existed, especially in the upper part of the city. He knows four men who will only allow prescriptions to go to one certain drug store.

Professor Remington exhibited a "cipher" prescription, in copy, that was sent to his store, and had been prescribed by a Professor in the University of Pennsylvania, and intended for a certain other drug store only.

Mr. Blair said the same Professor had diverted some of their customers to the same druggist.

Dr. Swayze spoke of a certain physician, now deceased, who was run down with business by the agency of certain druggists in different sections, and sent a patient eight squares to a certain apothecary for flaxseed meal to make a poultice.

Dr. Blackwood knew of but two druggists who did this kind of business; they were of inferior standing.

Mr. Niskey mentioned a private prescription put up by one party for $3, which he put up, after getting the formula, for fifty cents.

By general consent, it was thought proper to have no business intercourse with either druggists or doctors who were parties to the underhand conspiracy.

4th. Prescribing over the Counter and Renewing Prescriptions were considered together. Prof. Remington thought that nearly all druggists would recognize a request, written or printed on a prescription, "Not to renew." He had stopped renewing a doctor's prescription at his own request.

Mr. Needles thought by renewals of prescriptions a great injustice was done physicians. He personally knew of *one* doctor who had lost *many* dollars by the renewals of a certain prescription.

Mr. Niskey spoke of patients calling for copies of prescriptions, and undoubtedly having them often renewed. It was important to understand what the rights were in such a case.

Mr. Needles said he made it a rule not to give the original.

Mr. Blair said a printed request on blank would not always meet the case. He thought a private mark, such as (D. R.) "Don't Renew," would attain better results. He spoke of a prescription containing acid hydrocyan. given for an adult, but renewed for a child.

Dr. Blackwood spoke of a case of poisoning in a child, because of frequent and unauthorized renewals of a certain prescription.

It being the voice of several present, including Mr. Needles and Prof. Remington, Dr. Schoales moved that the consideration of these important points be continued to another meeting, and when we adjourn it be to meet in the College of Pharmacy, on Friday, October 1st, at 3 P.M. Adopted.

President Thompson embraced an opportunity to say that he hoped "we would come together in a friendly spirit, and we must do so, if we hope to accomplish the desired object."

As the hour was growing late, the meeting adjourned, as per resolution.

An adjourned meeting of the Committee of the Philadelphia Medico-Legal Society and a number of other physicians met, with a number of

pharmacists, in the Museum of the College of Pharmacy, October 1st, 1880. Dr Stubbs occupied the chair and Dr. R. G. Stretch acted as Secretary. The following physicians and pharmacists were present. Physicians: Drs. Stubbs, Swayze, Buckby, Nash, Prall, Mitchell, Butcher, Girvin, Graydon, Shelly, Crandall, Oliver and Stretch. Pharmacists: Prof. Remington. Messrs. Bullock, Magill, Niskey, Musselman, Thompson, Boring, Davis, West, Robbins, Blair, Naulty, Wall, Reiman and Wiley. The minutes of the last meeting were read and approved.

Dr. Swayze opened the discussion by alluding to the various questions which had been up for discussion at the previous meeting, together with the results obtained. He then continued, saying:—

We are here to-day to proceed with our deliberations, in a spirit of friendliness and fraternity. In the responses to the presentation of the subjects at our former meeting there were several points advanced by our pharmaceutical friends which deserve consideration at the outset to-day. One was, "Would physicians throw the weight of their influence in favor of such pharmacists as would honestly banish patent and proprietary nostrums and the other encroaching abuses specified, and confine themselves to legitimate pharmacy?" We unhesitatingly respond, we entertain no doubt that the honorable regular practitioners would do so in good faith. As a slight evidence of the earnest feeling of the profession on the subject of pharmaceutical irregularities, we have presented to just a few of the physicians of this city, for their signature, an Appeal to Pharmacists, which Appeal was immediately signed on the reading of its object; no one declining, but all affirming they were heart and hand with us in this needed work. We believe a canvass of this city would demonstrate that all thoughtful members of the medical profession cordially accord the same testimony.

Another point advanced by pharmacists was the large amount of money invested in patent medicines. If the point raised has reference to the interests of the *patent medicine maker* or *speculator*, it has no legitimate concern with our present issue. The fact that patent nostrum speculators put large capital into their speculation is not a reason why either physicians or pharmacists should loan these nostrum capitalists professional agency and influence towards coining fortunes out of the gullible public, and our local patronage in particular.

Patent nostrum speculations thrive because their local representatives enable them to thrive. But if the point advanced referred to the stock of these stuffs now in the hands of retail druggists, the problem is one of scarcely any significance, compared with the great fundamental principle of right and justice, for which we now respectfully but most earnestly contend.

Another point advanced was the old mooted one of proprietorship of the prescription. It was answered by one of our pharmaceutical friends; he believed it had been settled legally, that the prescription belonged to the patient. This is a misconception. If by this is meant that the pharmacist is under obligation to renew prescriptions, whenever the one prescribed for, or others, apply for such renewals, it is a misconception—even of statute—if there be any such. Law is the guardian of the public welfare; its spirit and purpose is that of protection. It does not give a man the right to abuse himself, or his family or neighbor. It does not, in spirit, authorize the jeopardy of health or life. The law recognizes the individual sovereignty of purpose. The spirit of the purpose is recognized as defining the merits of the acts. Well, now, the only problem to be grasped is the *purpose* of the physician in writing his prescription. The patient's health becomes disordered; the functions of a physician are deemed necessary. The physician's knowledge, and experience and judgment are brought into requisition. He considers the case, diagnoses the diseased actions, determines what remedies should be used in the case. He charges a fee; but does he charge for the professional service he has rendered, or does he *sell* the *prescription* (the mere directions he has given), for the amount of that fee? We never *sell* a *prescription* in such professional service, any more than does a commanding officer *sell* his *order* to another officer. Nor does the physician grant to the patient or the druggist any more right to repeat renewals of prescriptions, than does a commanding officer grant to a subordinate officer the right to repeat his orders at the wrong time or place, or repeat them at all unauthorized. If the physician has no moral right to jeopardize the welfare of his patient or the public, common sense must teach that he would not so stultify himself as to grant to the patient or the druggist a *carte blanche* privilege of doing what the doctor himself has no right to.

Dr. Oliver presented a Code of Ethics of the Pharmaceutical Association of Erie County, New York, and read a few articles from the same, showing that they discountenance the sale of nostrums, the giving of percentage on prescriptions, prescribing over the counter, or giving medical advice to patients.

Prof. Remington said the Philadelphia College of Pharmacy had had a Code of Ethics for the past twenty-five years; the College cannot control the graduates after leaving the school, as they scatter themselves all over the country.

Dr. Swayze said he understood the College had a Code of Ethics, but did not understand that it presented any definite restrictions against the practice of the abuses complained of, and read again from the printed appeal, that what was asked for was the adoption of "a *Medical and Pharmaceutical Code for our Mutual observance, by which the legitimate province of pharmacy and the professional rights of physicians shall be secured.*"

Dr. Oliver said if the College of Pharmacy has a code of ethics, it has been a dead letter for many years. He wanted a mutual code for pharmacists and physicians, if we could agree upon one.

Dr. Butcher thought we had better reason together, for the benefit of both physician and pharmacist.

The question of renewing prescriptions was now taken up.

Mr. Webb thinks the abuse of the renewal of prescriptions is not so great as many of us think.

Dr. Crandall said several of the members of our Society had informed him that their prescriptions had been renewed very many times without any authority from the physician; and by these renewals the doctors were deprived of receiving fees that they were justly entitled to.

Prof. Remington asked the physicians present if they had tried the experiment of asking pharmacists not to renew their prescriptions?

Mr. Thompson said that the physicians should tell their patients that the prescription is not to be renewed, and not put the burden upon the pharmacist to do so. By this means they would educate their patients in the matter.

Mr. Blair said he had often been placed in an awkward position, by having a physician tell him not to renew any of his prescriptions without a written order from the physician; and yet, perhaps in a few days, a perfectly reliable patient would come and tell him that the doctor told him to come and get the prescription renewed.

Dr. Prall asked if a good effect could not be produced if the pharmacist would paste a small label on the bottle, stating that the prescription should not be renewed.

Prof. Remington thought an excellent effect would be produced by this procedure, if the doctor's initials were used in connection with the above suggestion.

Mr. Blair thought the pharmacist had enough to do now without having extra labor put upon him for which he would receive no pay. As the physician generally saw his patient in a place more quiet than the apothecary store, he thought it was the physician's place to inform the patient that the prescription was not to be renewed.

Mr. Bullock said we must remember that the public stand between the physician and the pharmacist, and they assert we cannot stop them from the privilege of having prescriptions renewed. But he thought the physician should educate the patient up to the point that it is unsafe to take medicine without the physician's orders.

Dr. Prall asked, what will druggists do if they get prescriptions containing calomel? His friend, Dr. Sommers, wrote a prescription with calomel in it and it cured a very sick child. The family were pleased and retained the box containing the powders, with a view of having them renewed for any other sickness in the future. Another child was taken sick, and without consulting the Doctor they renewed and used the powders, and continued to use them for a long time; the child was salivated, and finally died. The family censured the Doctor and never employed him afterward, although he did not order or know they were using the medicine for the child.

Mr. Boring said many pharmacists, before renewing a prescription, ask whether the doctor has ordered it to be renewed.

Mr. Bullock said many patients have had the prescriptions of Doctor Physic and other old physicians put up, even to this day; and that no one can deprive them of the right to have any prescription compounded as often as they wish. Still, he would like to see the matter settled to the satisfaction of the physicians.

Prof. Remington said no law can stop a patient from salivating himself, if he wishes to. We pharmacists keep *open shops*, and sell whatever is called for. Still we are as careful of the lives of patients as the physicians are. He mentioned that Doctor Henry M. Smith had printed, in red letters, on the top of his prescription blanks, a request *not to renew his prescription*. In one instance, on refusing to renew such a prescription, the patient required me to give him a copy of the prescription, and he went to the next pharmacist and had it put up. He said these meetings will accomplish some good, as it gives a chance to hear both sides of the question.

Dr. Oliver asked if any respectable pharmacist would put up a prescription, unless it was by the orders of a physician? And whether they did not in all cases write the name of the doctor on the label, ordering the medicine to be taken in a certain manner? Now, can any pharmacist who renews a prescription without an order from the doctor, conscientiously say, "*Take as ordered by the physician*," when the doctor has no knowledge of the patient having had it renewed? He thought all respectable pharmacists, if the doctor would make the request, would not renew the prescription, but would honor his request.

Dr. Prall said the most practicable way of rectifying the difficulty is by a mutual Code of Ethics between the doctors and druggists. The druggists can then all the time discourage renewals, as a duty, especially when the ingredients are injurious if taken for a considerable length of time; and thus gradually educate the people.

Mr. Thompson replied that his idea of a Code was that it was *all bosh!* made *to-day* and broken *to-morrow*.

Dr. Butcher said it was in consequence of pecuniary losses to physicians that they object to the miscellaneous renewals of their prescriptions. It is an injustice to us to have such constant renewals. The druggists can easily say they cannot renew, and the public will not demand renewals. The "dear public," is here thrust in; there is a great concern about the rights of the "dear public." I'm as much a friend to the "dear public" as anybody, but I'm a friend to my own rights also.

Mr. Bullock said he thought physicians should try making a request on their prescriptions first, and all good pharmacists would, he thought, try to honor the request; we can see what this will accomplish if the physicians adopt it.

Mr. Davis asked that physicians write the request with their initials attached, to give the druggist something to stand behind as a special order. No druggist of character would renew a gonorrhœal, or similar mixture, without an order to do so.

Mr. Blair offered the following resolution:—

"*Resolved*, That physicians, when writing a prescription which they do not wish renewed, should write on the bottom of such prescription, "Do not renew," and also inform the patient of the fact in every case."

Mr. Mitchell thinks that the *written* request will prove an important feature in restricting the druggist.

Dr. Butcher offered an amendment to Mr. Blair's resolution, as follows: "And, on the other hand, the druggist will either write or print on the label upon the bottle or package, "*Not to be renewed unless by a written order of the doctor.*"

The resolution, with its amendment, was adopted.

Dr. Buckley thinks we must at last come to a mutual Code—a house whose roof would be ample enough to protect us all.

On motion, the meeting adjourned to meet on Friday, October 8th, at half past three P. M.

THE BRITISH MEDICAL ASSOCIATION.

(*Continued from page* 322.)

The Section of Obstetric Medicine was opened with a paper by Dr. Lombe Atthill, on

Uterine Hæmostatics.

Dr. Atthill said that he would confine his remarks to the means of arresting hemorrhages from the unimpregnated uterus. He said that the most common causes giving origin to uterine hemorrhage, unconnected with the actual existence of pregnancy, were: 1. The various forms of cancer; 2. Tumors of the uterus; 3. Imperfect involution of the uterus after labor or abortion; 4. Granular erosion of the cervix uteri; 5. A granular condition of the intra-uterine surface; 6. Retention of a portion of the ovum after abortion. 1. Cancer was placed first on the list of causes, because its treatment by the administration of Chian turpentine, as advocated by Mr. John Clay, of Birmingham, had attracted general attention. Dr. Atthill's opinion of the drug as a hæmostatic, in some cases of cancer, was very favorable; but he could not confirm to the full extent Mr. Clay's views as to its curative powers in malignant disease of the uterus. It seemed to exercise its greatest power in cases of epithelioma of the cervix, and to have comparatively little influence in the medullary form of the disease. The value of turpentine in cancer of the uterus seemed to be mainly due to its action in diminishing the blood-supply. Dr. Atthill related the case of a lady who came under his care in September, 1879, suffering from a severe attack of uterine hemorrhage, which proceeded from an epithelioma of the cervix uteri. The hemorrhage was checked by the application of the strong solution of perchloride of iron; but, as the disease steadily progressed, the diseased structures were removed with the scoop and knife, on December 1st. The patient rapidly recovered; but in February the hemorrhage recurred, and the disease was found to have extended into the cavity of the uterus. The diseased mass was removed; but the hemorrhage continued in spite of the use of perchloride of iron. In March, Dr. Atthill began to administer pills of three grains of Chian turpentine with two of sulphur, eight to be taken daily. For some time the hemorrhage was much lessened, and almost disappeared; but lately there had been a return of the bleeding to an alarming extent. The patient had taken the Chian turpentine daily, from the time of its first prescription. The small supply of Chian turpentine, and the difficulty of obtaining it pure, were serious objections to its use. Dr. Atthill believed that a pure oil of turpentine, administered in from ten- to twenty-drop doses, three or four times a day, was, as a hæmostatic, quite as good; and that, if carefully rubbed up with powdered gum arabic or tragacanth, it was likely to agree with most patients. He had also administered the confection of turpentine with advantage. 2. To restrain the hemorrhage from fibrous tumors, the injection into the uterus of the liquor ferri perchloridi, and of the tincture of iodine, had been advocated. This method was sometimes followed by satisfactory results; but it was not absolutely safe, and, unless care were taken to provide a free exit for the fluid injected, either by previously dilating the cervix uteri or by using a double cannula, serious results might follow. The injection of hot water in such cases was a far safer method of restraining the hemorrhage. Incising the cervix was often useful, in being followed by a diminution in the hemorrhage, and by relief from pain; and at the same time it permitted the introduction into the uterus of a tube of moderate size and the free return of the hot water, which should be injected at a temperature of about 110° Fahr. Another simple and often effectual method of applying heat was the use of Chapman's spinal hot water bags. Of drugs, none could equal ergot in its power of restraining the hemorrhage depending on fibrous tumors. It was most effective when administered hypodermically. 3. Imperfect involution of the uterus implied, primarily, a relaxed state of the muscular tissue of the organ, and an unduly distended condition of the uterine vessels; and, also, in most cases, an unhealthy condition of the intra-uterine mucous membrane. When the latter existed, it must be cured by treatment directed to the intra-uterine surface. To check the hemorrhage at the time of its occurrence, hot water was a safe plan of treatment, and generally easily carried out. Ergot, quinine, and strychnine were, in cases of imperfect involution of the uterus, indirect hæmostatics. In the chronic form of the affection Dr. Atthill had administered Chian turpentine with benefit. 4. Hemorrhage due to a granular condition of the vaginal aspect of the cervix might be arrested by the direct application to the bleeding surface of almost any astringent; but, to prevent its recurrence, a healthy condition of the cervix must be brought about by the free application of some strong caustic. 5. The retention of a portion of the ovum after abortion sometimes gave rise to very troublesome hemorrhage. In such cases, dilatation of the uterus and removal of the retained portion by a curette might be performed unless contraindicated, but it was liable to give rise to cellulitis and even peritonitis; and Dr. Atthill, therefore, strongly recommended in such cases, at least as a preliminary measure, the syringing out the uterus with hot water. He had no faith in the administration of astringents by the mouth, in cases of uterine hemorrhage depending on the causes which he had enumerated. In

conclusion, he suggested that the most important questions for discussion, in connection with the subject of uterine hæmostatics, were these: 1. What is the value of Chian turpentine in arresting hemorrhage in cases of cancer of the uterus? 2. Is Chian turpentine the only variety of the drug of use in such cases? 3. In what other forms of uterine hemorrhage is the administration of turpentine indicated? 4. What is the value of the intra-uterine injection of hot water: (*a*) in cases of hemorrhage depending on the existence of fibrous tumors of the uterus; (*b*) in cases of imperfect involution of the uterus; (*c*) where portions of the ovum have been retained after abortion?

After a very active discussion and the reading of a few minor papers, Mr. Spencer Wells opened a discussion on

The Removal of Uterine Tumors by Abdominal Section,

with the following remarks: I wish particularly to limit this discussion precisely to the consideration of the subject of removal of uterine tumors, myoma, fibro-myoma, or fibroma, by abdominal section. Such a tumor as that on the table, which was removed by Mr. Sherburn, of Hull, from the uterine cavity and vagina, and the removal of fibroid polypi, or the enucleation of ingrowths which project towards the uterine cavity, are beyond the scope of discussion to day. And so is excision of the uterine uterus for cancer, by Freund's method, or any other; and the operation of Porro, so interesting to the obstetrician, where, in addition to the Cæsarean section, the uterus itself is excised after withdrawing the child. All these subjects are well worthy of separate discussion; and I hope they will be carefully criticised as soon as a sufficient number of facts, carefully observed and faithfully recorded, have been collected to form a groundwork for the formation of sound opinion. My object to-day is to obtain from members present any such additions to our knowledge as may assist in the formation of professional opinion upon the removal of fibroid outgrowths from the uterus towards the peritoneal cavity, sub-peritoneal outgrowths with a more or less perfect pedicle, or fibroid enlargements of the fundus, which may be removed with some part of the uterus itself, and with or without one or both ovaries at the same time, by a division of the abdominal wall as is made in ovariotomy, but necessarily longer when the tumors are both large and solid. And, as I understand opening a discussion to differ from reading a paper, in so far that in the former case one hopes to elicit information from others, while in the latter we endeavor to relate what we have ourselves observed or thought, I shall now only sketch so much of my own doings and reflections as may induce others to narrate theirs, and thus assist in the removal of the doubts and difficulties which necessarily obscure any comparatively new subject at its rise and during its early progress.

In the Hunterian Lectures at the College of Surgeons, which I delivered in June, 1878, I reported all my cases of removal, or attempted removal, of uterine tumors through the abdominal wall; and arranged them in two tables, one containing all the necessary details of twenty-four cases where uterine tumors were removed, with or without one or both ovaries; and twenty-one cases where only an exploratory incision was made, or where, in addition, the tumor was either simply punctured or partially removed. I must refer any one who wishes to examine this subject more carefully hereafter to the published tables. I can only say now, that of the twenty-four cases where the tumors were removed, only nine of the patients recovered, and fifteen died; while of the twenty-one cases of incision, puncture, or partial removal, only one died, and twenty recovered from the operation, some of them more or less relieved by it. I ask your attention to this mortality of sixteen deaths in forty-five operations, because this represents the results of my practice before adopting, in these operations, the Listerian details of antiseptic surgery. Since the delivery of the lectures, I have operated antiseptically, and I have had ten cases of removal, with three deaths and seven recoveries; and five cases of incision and puncture, all recoveries; or three deaths in fifteen operations. My whole experience, then, amounts to sixty cases: thirty-four of removal, with eighteen deaths and sixteen recoveries; twenty-six of incomplete operation, with only one death. The smaller mortality since adopting antiseptic precautions is certainly remarkable; but I do not wish to enter on this wide question now. I rather desire to discuss the indications which should guide us in deciding whether to leave a patient to her fate, or to medical treatment by ergotin or anything else; or to advise her to submit to the risk of abdominal section. It must be remembered that the risk, very small indeed, if the attempt end in incision and puncture only, is now considerably smaller than it was a few years ago, and may be expected to become much smaller as experience increases, and the details of the different steps of the operation are more carefully studied and more frequently practiced.

In the discussion which followed Mr. Knowsley Thornton said that the first point to be dealt with in the discussion of this subject was the question as to how far the removal of uterine fibroids by abdominal section was justifiable. He would simply say, under this head, that he did not think surgeons were ever justified in operating until all medical measures of treatment had been exhausted without such relief as enabled the patient to live in tolerable comfort. In those cases in which operation was necessary, what was to be arrived at was the perfecting of differential diagnosis. This was often extremely difficult, but was of the utmost importance, because on a correct diagnosis of the kind of fibroid operative procedure must depend. There were three classes of tumors: 1st. Sub peritoneal fibroids which were more or less pediculate; 2d. Sub-peritoneal fibroids which were sessile, and intramural fibroids; 3d. Tumors which so involved the uterus that it was necessary, for cure, to remove the whole supra vaginal portion of the organ. The operations in these three classes differed very much in gravity; hence the importance of correct diagnosis. Now, thanks to Mr. Lister, exploratory operations could be made with per-

fect safety, and these would teach much; so that diagnosis would improve apart from the information gained in the individual case. In class 1, with Listerism, tumors might be removed with little or no danger. In class 2, though apparently the operation was not so favorable as that required in class 3, the cases were really more fatal, as far as his experience went. In class 3, both ovaries were usually removed along with the uterus, and these cases appeared to do best when Mr. Spencer Wells' clamp was used. To this class he would restrict the use of the term "hysterectomy." In the other classes, the ligature or the cautery, and intra-peritoneal treatment, answered best. He thought that the method of sewing up only the peritoneal surfaces, as suggested and practiced by Mr. Wells, was preferable to Schroeder's plan in cases in which it was necessary to open the uterine cavity.

Mr. Lawson Tait had performed seventy-three ovariotomies, with two deaths; since then, he had done thirty-three operations without a death. The tumors were divided into three classes: 1st. Those requiring enucleation; 2d. Those requiring abdominal section; 3d. Those best treated by removal of the ovaries. His results in enucleation were very unsatisfactory. In those cases where abdominal section was used, five died out of nine. His views on this point agreed entirely with those of Goodell. But as regarded removing the ovaries, he had a different story to tell. In future, he should seldom use either of the first two operations; but the third he had performed thirteen or fourteen times, with only one death; and he had determined never again to remove a uterine tumor by abdominal section, unless the tumor was of enormous size, or was pressing injuriously upon some organ. In all the cases where he had removed the ovaries, the hemorrhage was completely arrested. He related a case in which this was very well brought out. In this one, as well as stoppage of hemorrhage, the tumor was becoming smaller. He had observed this reduction of size in other cases also. He should in future always perform oöphorectomy before attempting to remove the tumor.

Dr. Marion Sims thought Mr. Wells was right in dividing his series of cases according as they were performed antiseptically or not. This system had revolutionized surgery. As far as removing tumors by abdominal section went, there were some cases in which they must be removed on account of their size or pressure. He quite agreed that oöphorectomy would in future be very generally used in cases of bleeding fibroids. He had seen some tumors reduced in size to an enormous extent by the mere lapse of time and advance of life, and related a very remarkable case of the kind, where a tumor, which must have weighed about thirty pounds, in ten years had quite disappeared. He would have liked more details of Mr. Wells' fatal cases. He would prefer Péan's method to that of Schroeder in removing uterine tumors. Removing the whole organ was a safer operation than cutting out a portion of it.

Several other members also took part in the discussion, after which, the Section closed with a paper by Dr. H. MacNaughton Jones, on

Obstetrical Knowledge in its Relation to the Present Standard of Medical Education,

in which he drew attention to the disproportion between the obstetrical and gynæcological acquirements necessary in the practitioner, and the opportunities of learning afforded in many of the schools. Dr. Jones concluded by putting three propositions before the Section: 1. The efficient teaching of an obstetric class cannot be effected in a course of less than one hundred lectures. In schools where the winter session does not embrace this number of lectures, either an additional summer or winter course should be required before the candidate is permitted to present himself for his final examination; there being an understanding that the lectures on gynæcology are delivered as a distinct part of the course or courses attended by the candidate. 2. An attendance on at least twenty cases of labor should be required of the candidate, before he is permitted to present himself for final examination; these cases to be attended in some recognized hospital, or maternity, or under the supervision of a recognized teacher. 3. The candidate should be required to produce proof, by notes of cases or otherwise, that he has attended in the wards or externe department of a general hospital, or hospital specially devoted to the treatment of such diseases, a given number of cases of uterine disease.

[*To be continued.*]

Editorial Department.

Periscope.

Nitrite of Amyl in Convulsions.

Dr. Leonard F. Pitkin, of Ravenswood, Long Island, reports the following case in the *Medical Record*, October 2d, 1880:—

Willie R., aged two years and six months, while at play on the morning of August 12th, was suddenly seized with convulsions. I was immediately summoned, and on my arrival I found the child in an unconscious state, one convulsion following another in most rapid succession. The convulsive movements were confined almost entirely to the right side. My first impression was that the convulsions were due to functional derangement of the stomach and bowels, and the usual remedies indicated in such cases were resorted to, but no benefit followed the same. As the child was, in the meantime, rapidly becoming exhausted, and the necessity of doing something to control the convulsions more evident, I

resorted to the use of chloroform and ether, but without succeeding in controlling the convulsions. I then used nitrite of amyl by inhalation. Placing four drops on a handkerchief, I applied it to the child's nostrils, and after a few moments had passed the convulsions ceased entirely, and did not occur again till yesterday morning, August 13th, but were immediately controlled by four drops of amyl nitrite, and have not occurred since. A closer examination of the patient reveals that the convulsions were evidently due to some cerebral lesion. The cranium is markedly asymmetrical; pupils unequally dilated, the left being much larger than the right. The head is not abnormally large, but the posterior fontanelle is perceptible, union not having taken place between the bone, and remarkably large, being an inch and a quarter in diameter at its base. There is evidently some serous effusion in the membranes of the brain. Child is now taking—

℞.	Potass. iodidi,		gr. x.
	Brom. potass.,		gr. xl.
	Aquæ,		
	Syr. rhei.,	āā	℥j.

Sig.—Teaspoonful t. i. d.

Child is well nourished; appears strong and healthy. On questioning the mother, I ascertained that she has lost two children, both dying in convulsions, which were like this one. I have used the amyl nitrite in a large number of cases, and, with few exceptions, it has been followed with good results. I usually administer five minims, dropping it into a small sponge, allowing the patient to inhale it. It causes the face to flush, and stimulates the lachrymal glands to a considerable extent. Great care should be used in the administration of the drug, as serious consequences might result from its injudicious use.

A New Method of Treating Endometritis.

Dr. S. S. Boyd, of Dublin, Ind., in a communication to the *American Practitioner*, for October, 1880, says:—

Within three years I successfully treated, by a method original with me, a very obstinate endometritis, occurring in a woman twenty-five years of age, who had been married five years. During all of her married life, until recently, she suffered from a constant flow of muco-purulent discharge from the uterus, with all the attendant symptoms of endometritis. Much of the time she was scarcely able to walk about the house. During the two and a half years which I treated this patient, I exhausted all of what I considered safe remedies, both topical and general, with but little benefit. Finally, I adopted the following plan of applying nitrate of silver to the endometrism:—

Taking a small female silver catheter, I had it cut in two, so as to leave three inches of the closed end in one piece. In three-fourths of an inch of this closed end I had as many small perforations made as could be, without materially weakening the walls of the instrument, and to the outside of the open end a ring was soldered, to which a small cord could be attached. Having on the day previous to that on which I used this instrument introduced into the uterus a slippery-elm tent, retaining it in place by a pledget of cotton wool, I let the tent remain over night. Putting about fifteen grains of coarsely-pulverized nitrate of silver in the tube above described, and confining it there by pressing a little cotton on it, I then tied a small cord, six inches long, to the rim, when it was ready for use. Removing the plug and the tent after introducing the speculum, I inserted the silver tube into the uterus, until the distal end reached the fundus, securing in place as I did the elm tent, leaving one end of the cord outside the vagina. This was done as a precaution against any serious pain in my absence, in which case the patient could remove the tube. But it was not found necessary to remove the instrument for three or four hours, and then the nitrate of silver was dissolved.

Briefly, the foregoing treatment was that which finally relieved a long-suffering patient, in less than six weeks, by four applications one week apart. Of course, I did not neglect to administer iron, sulph. quinia, ale, and ext. malt, as I consider constitutional medication in such cases essential to the relief of the local disease.

As this mode of topical application to the internal uterus was tried in but a single instance, no certain deduction can be drawn as to its general adaptation to the cure of endometritis, and yet, from its complete and speedy success in this single case, I am led to hope it may prove a valuable addition to the local treatment of this form of uterine disease.

Iodide of Potassium in Typhoid Fever.

Dr. C. G. Bryan says, in a communication to the *North Carolina Medical Journal*, for September, 1880—

During the last two years I have used iodide of potassium in several dozen cases, and I am forced to the opinion that when it is used persistently from the time the first symptoms make their appearance, it will either break up the attack in from one to two weeks, or render it much milder than if the expectant plan of treatment had been pursued exclusively. I could cite many instances illustrating the comparative results of the treatment of cases, in some of whom (partly for the sake of experiment) I employed the potash from the beginning, while in others the expectant plan was pursued. Suffice it to say, however, the result was nearly always very decidedly in favor of the former. Of course, I would not use potash to the exclusion of all palliatives in every case. I do not pretend to say whether it acts by neutralizing the typhoid virus, or whether, by exciting the secretions, it causes nature to throw off the poison more rapidly; but when the stomach and bowels are not too irritable to tolerate it, I regard it as the surest remedy in the treatment of typhoid fever.

I would be glad to know if any practitioner has used to much extent, iodide of potash in the treatment of typhoid fever; and if so, at what conclusion has he arrived as regards its remedial effects?

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——*Harper's Bazar* continues to come to us, full of the latest fashions and many other matters of interest.

——Dr. Boardman Reed, of Atlantic City, sends us, in a reprint from the *Medical Bulletin*, a paper on *Hygiene at the Seashore.*

——No. 1 of the *Medical Library Journal*, published in Boston, has just reached us. It contains as leading articles a number of critical book reviews, some well written editorials, biographies and other matters. Price, $1.25 per annum.

——We have just received a pamphlet on *The Rise of American Dermatology*, being the President's Address before the third Annual Meeting of the American Dermatological Association, held at New York, August 26th, 1879, by Louis A. Duhring, M.D. Extracted from the Transactions of the Associations.

BOOK NOTICES.

Transactions of the Southern Illinois Medical Association for the year 1880, held at Cairo, Ill., January 21st, 22d, 1880, and Shawneetown, Ill., June 23d, 24th, 1880. Vol. ii. St. Louis, George O. Rumbold & Company. pp. 92.

Among the papers in the Southern Illinois Transactions, we notice; "Adherent Placenta," by Dr. H. D. Ferrell, of Carterville; "Hot Water in Uterine Hemorrhage," by Dr. W. R. McKinzie, of Chester; "The Waters of Hot Springs," by Dr. J. L. Gebhart, of Hot Springs, Ark.; "The Treatment of Post-partum Hemorrhage," by Dr. George J. Engleman; "Cancer of the Stomach," by Dr. S. W. Marshall, of Sparta; and several others.

The Microscopist: A Manual of Microscopy, and Compendium of the Microscopic Sciences; Micro-Mineralogy, Micro-Chemistry, Biology, Histology and Practical Medicine. Fourth edition, greatly enlarged, with 252 illustrations. By J. H. Wythe, A.M., M.D., Professor of Microscopy and Histology in the Medical College of the Pacific, San Francisco, Cal. Philadelphia, Lindsay & Blakiston, 1880. Cloth, 8vo., pp. 434. Price $5.00.

After a brief allusion to the application of the microscope to science and art, and the progress of microscopy, the author proceeds to give a description of the various microscopes constructed, with their accessories, together with general directions for their use and the various methods of examination, as well as mounting and preserving microscopic objects. He then takes up for consideration the following subjects: "The Microscope in Mineralogy and Geology; in Chemistry; in Biology; in Vegetable Histology and Botany; in Zoology; in Animal Histology; in Pathology; in Diagnosis; and in Ætiology." These various subjects are treated of in an exhaustive and thorough manner, in which the elegantly colored plates and other illustrations lend material aid. There is also an appendix, containing a description of the recent additions to the microscope and microscopic technology, and the various improvements in mechanism, together with a classification of cryptogamia; and finally, an index and glossary. To those interested in microscopic investigations, the book cannot but prove of the highest value. The purely mechanical execution of the work is unexceptionally good.

Hygienic and Sanative Measures for Chronic Catarrhal Inflammation of the Nose, Throat and Ears. Part I. By Thomas F. Rumbold, M.D. St. Louis, Geo. O. Rumbold & Co., 1880. Cloth, 12mo, pp. 174.

The author informs us, in the preface of his book, that he had been but a few years in the practice of this specialty, when he perceived that the successful management of chronic catarrhal affections depended on the faithful observance of the laws of health by the patient. He therefore, as far back as 1862, began to give such rules to his patients as observation taught him were beneficial in guiding them through those seasons of the year in which they were most liable to take cold. The work is divided into nineteen chapters, the first eleven of which comprise such hygienic measures as the protection of the various parts of the body by proper clothing; the temperature and ventilation of rooms; diet and stimulants; exercise; disposition of the mind, etc. In the remaining eight chapters, such direct sanative measures as cleansing the nasal and naso-pharyngeal passages and the ears; the care of the teeth; bathing; the inunction of the body with oily substances, etc., are discussed. One chapter is devoted entirely to the effects of tobacco, showing that its continued use unquestionably predisposes to catarrhal diseases. The book is written in plain and unobtrusive language, and its teachings appear to be based on a large experience and careful observation. We heartily recommend it, not only to the profession, but to others who have the good sense to understand that "prevention is better than cure."

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

WOMEN AS DELEGATES AND WOMEN'S BRAINS.

As has before been announced in this journal, an "International Medical Congress" is to meet in London next year, from the third to the ninth of August. The President is to be Sir James Paget, Bart., and the Hon. Secretary is William MacCormac, Esq., 13 Harley Street, London, W., to whom we may say, *en passant*, communications respecting the Congress may be addressed.

We refer to the Congress just now, on account of one proposed peculiarity in its organization. This is, that female practitioners of medicine are to be excluded. At least, this is taken for granted by the English journals. The *Lancet* says:—

"Invitations to attend the meetings will be issued to all legally qualified medical practitioners in the United Kingdom, and will be sent to the different countries of Europe, to America, the Colonies, and India. Papers may be read in English, French, or German, and will be published in the volume of Transactions, in the language in which they are read. We presume it is only an oversight that the word "male" is omitted from the qualifications of those to whom invitations are to be sent. The names of many of the officers of the Sections are an assurance that the "lady doctors" will not be asked to attend and contribute; but if by any want of clearness in issuing the invitations mistake should occur, a very considerable proportion of the leading members of the profession will, of course, decline to co-operate.

Since this appeared, we are informed that it has been definitely decided that they shall not be admitted.

This, we submit, is a small-minded, illiberal, unworthy piece of business; and the American and European profession ought to unite in condemning it. We have in this country several regular medical colleges of the best repute, for women; graduates of such colleges are admitted to numerous medical societies of the highest character; medical literature owes to women some of its most able recent contributions. So in Europe, several Universities admit women to all the privileges of their medical courses; and in both continents there are women practitioners in numerous cities every whit as well qualified for their business, and as ethical in its pursuit, as their male competitors. Such being the undisputed and indisputable facts, the petty prejudices of a few Englishmen have no right to control the attendance on an "International" Congress. Let them confine the imposition of their narrow opinions to their own household, so long as these are willing so to be nose-led; but when it comes to a World's Congress, the insular prejudices of a few "officers" have no business to be thrust forward, with a pretence of controlling what sort of a delegate the national Medical Associations of Switzerland, Russia, or the United States shall send. It is a piece of impertinence.

It is amusing to see the efforts which various English writers make to convince themselves and others that woman is intellectually inferior. Their settled opinions on this subject having received a rude shock by the result of the examinations of female students at Oxford, Cambridge and the University of London (which threatened to show that they were not only equal but ahead of the male students

of the same ages), the cerebrologists have rushed to the rescue, to prove that the female brain is smaller than that of the male, and therefore, whatever examiners say, she can't be so "clever." The latest is Dr. Crichton-Browne. He thinks that the difference in weight of the brain in the two sexes is not to be accounted for on the score of the general difference in stature and bulk, as that is not shown to reach the percentage, 11.4, established by his tables as the difference in brain weight. He does not, moreover, think that this is the true difference, but concludes that in perfectly healthy persons the balance in favor of the male sex will be shown to be more than 136.2 grams. He says —

"All available evidence, therefore, points to the conclusion that the brain of the male exceeds that of the female, in weight, to a greater degree than has been heretofore currently reported, and that the relatively small size of the latter is not to be accounted for by deficiency in stature or weight, but depends, as Broca has argued, as much on her intellectual as her physical inferiority."

Poor Broca! He was a rather small man, but he had, for his size, a remarkably big head, of which he was very proud. Perhaps it was partly this which led him to teach that a man's intelligence is in proportion to the size of his brain. He did not object to the suggestion that he was a striking example of his own theory, and certainly he had a prodigious memory, and an encyclopædic knowledge.

But alas for his theory! A big head does not always mean a big brain, and when they came to weigh Broca's, it was not quite 1400 grams; whereas, the weight of the brain, taken at all ages in males, is 1335 grams; consequently Broca's was not above the average of his adult neighbors. So that in spite of Broca and Browne, it still holds good that it is the distribution and quality, not the mere size of the brain, which are the physical exponents of intellect; and when it comes to these characteristics of brain, it is quite likely that woman will show as well if not better than man. At any rate, it is a weak cause that seeks prejudgment from doubtful and irrelevant statements.

Notes and Comments.

Therapeutical Notes.

OINTMENT FOR SCABIES.

Dr. O. H. McAllister, of McAllisterville, Pa., physician in charge of the Soldiers' Orphan School at that place, sends us the following formula, which he has found efficacious in curing scabies, with which the children of the school had been afflicted for a long time:—

℞.	Hydrarg bichloridi,	ʒij
	Pulv. capsici,	ʒj
	Pulv. sulphur.,	ʒiv
	Adipis,	℔iv. M.

Sig.—Mix by gentle heat and keep stirring it constantly while cooling.

Abortive Treatment of Boils.

At a recent meeting of the Adams County, Pa., Medical Association, Dr. J. W. C. O'Neal, of Gettysburg, reported a prompt and efficient abortive treatment of boils and carbuncles, by the hypodermic injection of carbolic acid. The plan had been effectual in several cases of painful carbuncles, situated on the back of the neck, and in boils near the anus. Two of the medical gentlemen present, who had been subjected to the treatment, described the pain of the injection as being like the sharp sting of a wasp, lasting but three or four minutes, and then followed by complete relief, and subsequent resolution of the disease. Carbolic acid, pure, two-thirds to water one-third, was used, from six to eight drops of the solution being deeply injected into the centre of the tumor.

Tracheotomy Superseded.

In the *British Medical Journal*, July 24th, 31st, Dr. McEwen, of the Glasgow Royal Infirmary, advocates the use of tracheal tubes by the mouth instead of tracheotomy. He gives three cases in which he had recourse to the tubes, and their use was attended with very good results. Two were for the relief of œdema glottidis, and one to occlude hemorrhage from the larynx during an operation. The practical conclusions which he draws from these cases are as follows. 1. Tubes may be passed through the mouth into the trachea, not only in chronic, but also in acute affections, such as œdema glottidis. 2. They can be introduced without placing the patient under an anæsthetic. 3. The respirations can be perfectly carried on through them. 4. The expectoration can be expelled through them.

5. Deglutition can be carried on during the time the tube is in the trachea. 6. Though the patient at first suffers from a painful sensation, yet this passes off, and the parts soon become tolerant of the presence of the tube. 7. The patient can sleep with the tube *in situ*. 8. The tubes, in these cases at least, were harmless. 9. The ultimate results were rapid, complete, and satisfactory. 10. Such tubes may be introduced in operations on the face and mouth, in order to keep blood from gaining access to the trachea, and for the purpose of administering the anæsthetic; and they answer this purpose admirably.

The Use of Chloral in Phthisis.

A Russian doctor writes to the *St. Petersburg Medical Gazette*, on the "Utility of Chloral in Phthisis." In every case he had administered it he never had had the slightest accident. Sleep had been always calm. The physical symptoms were less evident in the morning; the patients felt themselves better and stronger; never did they complain of headache. When the chloral was suspended insomnolency appeared. The author sums up with the following conclusion: Chloral, as a hypnotic is by no means indicated in phthisis. In the dose of from fifteen to thirty grains it cannot do any harm, except in the last stage. It always procures refreshing sleep. It diminishes the sweating and checks the losing of weight. It lowers the temperature, increases the urinary secretion, and does not produce headache nor disturb the digestion.

Beef Tea and its Value.

Certain iatro-chemists and iatro-physiologists, not being able to discover what were the nutrient elements in beef extract and beef tea, have of late years much decried those preparations. At most, they allowed them to be "condiments." Fortunately, common sense and clinical experience are gaining the day over the theoreticians, and we take pleasure in publishing the following details contributed by Mr. Wilkinson, House Governor of St. Mary's Hospital, London, to the *British Medical Journal*:—

The mode of preparing beef tea at St. Mary's Hospital is as follows: The meat is cut into small pieces, and placed, in the evening, in an earthenware vessel, with sufficient cold water to cover the meat; in this it is allowed to remain all night. In the morning the meat is taken out, placed in other water, and boiled for several hours. The meat of the previous day is then passed through a mincing machine, and put into the cold liquor in which the meat was steeped the previous night, and upon this the boiling liquor from the day's beef tea is poured, and the whole well stirred, and it then forms the complete beef-tea. The characteristics of good beef tea are, that all the nutritious elements of the beef should be made available; and by the process carried out as above, this is effectually done, the albumen, fibrine, and gelatine being all retained and taken by the patient. Moreover, by the above method a much smaller quantity of meat is required than under the ordinary mode, and it would, consequently, not become a jelly if allowed to stand; but by adding a larger quantity of beef this result could, of course, be obtained. (This forms with us what is called beef jelly.) It should, however, be remarked that in very hot weather the beef tea cannot be made in this manner, as it would become sour, from the length of time required for its preparation.

Treatment of Phthisical Cough.

Several correspondents give their experience on this subject, in the *British Medical Journal*:—

Dr. T. F. Pearse recommends the tincture of gelsemium sempervirens in twenty-five minim doses three times a-day. He generally prescribes it with dilute phosphoric acid. If there be much expectoration, compound tincture of benzoin is often useful.

Mr. T. Garrett Horder strongly advises hydrobromic acid in doses of twenty minims. It may be given with the addition of spirits of chloroform. He has also found the inhalation of the vapor of iodine very useful in chronic cough.

Another correspondent recommends fifteen minims of hydrobromic acid and ten minims of chloric ether in a dessertspoonful of water four or five times a-day, with a pill containing a quarter of a grain of codœia three times a-day.

Mr. A. de Winter Baker (Dawlish) recommends the following formula:—

℞.	Tincturæ pruni Virginianæ,	ʒj	
	Glycerini,	ʒss	
	Nepenthe, (Ferris and Co's.)	℥v.	
	Aquæ,	q. s.	M.

He generally orders it to be given when the cough is troublesome, and repeated in three or four hours, if required. In troublesome cases he also orders a double dose to be given at bedtime. He has never known it to fail to relieve cough; and it can be taken for a long period of time without disturbing the digestive organs.

Correspondence.

Nux Vomica in the Treatment of Rheumatism, Sciatica, Dyspepsia, etc.

Ed. Med. and Surg. Reporter:—

It has been my intention, for a long while, to send in an article on nux vomica; especially with regard to its influence on certain nervous diseases, covering quite a broad field. I have not a library of sufficient extent to study up the subject properly, and I am not at all sure that the ideas I will advance are original. The fact is, the preparations of nux vomica enter into the treatment of so many disorders, that an original thought on its use is next to impossible. However, if there is nothing original in what may be written by me, it may help some fellow practitioner out of a difficulty, and feeling this, I am emboldened to send it up. It has been suggested in paralysis, and indeed in all departures from a healthy condition of the nervous system. That the diseases I will report are of this family, I am assured; but I am not certain that nux vomica fills the place it deserves to fill in the treatment of rheumatism, sciatalgia, dyspepsia, etc.; for if it is not a specific, it is at least a remedy that may be relied on as promising more than any other remedy we possess. I will first report a case of chronic sciatalgia, and then one of dyspepsia, closing with some general remarks on rheumatism.

Case 1.—J. S., male, aged 45, of a nervo-bilious temperament. When called to him, he gave the following history of his case. For four or five years he had suffered excruciating lumbar pains—said pains extending down the thigh to the knee, and lower at times. About five months anterior to the time of my call had become much worse, he having to use crutches to get about. About one month before I was summoned he had to discard his crutches and to remain in bed. Said he had employed doctors at various times, but they had only given him temporary relief. I placed him on a tonic, but based my treatment on ½ to 1 gr. alcoh. ext. nuc. vom. three times daily. I used a liniment of chloroform, etc., but expected little or nothing from it. I encouraged him by telling him, in a month or so he would be up, yet I really did not believe such a thing possible. After giving the solid ext. awhile, I gave the fluid ext. nuc. vom., in four to six drop doses thrice daily and strange as it may appear, he recovered rapidly, and to-day, nearly four years from my visit, he seems to be in good health, and is never troubled with his old and very persistent, as well as painful, enemy.

Case 2.—J. W., aged 40, of a rather sanguine temperament, consulted me January 1st, 1880, with regard to marked debility, and to use his own words, "a constant spitting up of anything he would eat." I advised him to use fld. ext. nuc vom., three to five drops three times daily, until he improved, if it took six months; and in the meantime, to report to me any change there might be in the case. He went his way, and I neither saw nor heard from him until last week, eight months from the time of the prescription; and he then informed me his dyspepsia had entirely disappeared a short time after he began the use of the medicine, and it had not troubled him since. Query? Is there not a too thorough medication, as a general thing, in the treatment of dyspepsia?

In the treatment of both acute and chronic rheumatism I have used the above remedy with occasionally very happy results.

I insist, if its use is persisted in, nothing but a good result may be expected; and in my experience there is no remedy that will do half as much in a given time, the alkali and anti-alkali treatments of the different authorities to the contrary notwithstanding. J. E. Stinson, M.D.

Montague, Texas, September 14th, 1880.

A Case of Amputation at the Knee Joint, With Recovery.

Ed. Med. and Surg. Reporter:—

Since amputation at the knee joint has been revived only within a few years, and as some appear yet to fear the consequences of attacking the larger joints, and for a still further reason, given by one of my distinguished professional brethren—"you may save some poor fellow from a suit for malpractice"—I thought it advisable to give to your readers the history of a case which, so far as I know, stands alone in this section of country.

About three o'clock in the afternoon, May 28th, Adam Snyder, a farmer, aged fifty years, while felling timber, was struck by a falling tree, and had his right leg terribly crushed. Dr. Morrison, of Donegal, was immediately sent for, and as soon as he discovered the extent of the injury, dispatched a messenger to our office, twelve miles distant, for assistance. I started as soon as possible, reaching Donegal at ten o'clock, and when we arrived at the house of Mr. Snyder, it was near midnight. It was not hard to decide that amputation was necessary, but where to amputate was the question.

Putting our patient under an anæsthetic, and making a thorough examination, I found that the soft parts were crushed, the muscles being torn into shreds, and the bones comminuted, the fractures extending even through the articular surface. We decided to operate at the joint.

I made a semilunar incision anteriorly, close to the inferior border of the patella, cut through the ligaments, disarticulated the joint, brought my knife out low down on the muscles of the calf, making a long, heavy flap.

The condyles and patella were allowed to remain, the latter fitting nicely into the space between the former, the flaps were brought together and dressed in the usual way, with stitches, adhesive strips and bandage, and healed rapidly, without any untoward symptoms, making a complete cushion over the articular surface, and forming a nicely rounded stump.

Shortly after the operation an aged "quack," of a neighboring town, wisely announced to some friends of our patient that "the stump would never heal, the man would die, and they ought to be prosecuted for malpractice;" and some few were found willing to believe him, until time proved the fallacy of his statement and exposed his ignorance.

Surely, it makes a more solid stump, as well as lessens the danger both from pyæmia and the nearer approach of the knife to the body, to amputate at the joint, than to go above.

About three weeks after the operation an abscess formed about the middle third of the thigh, which for several days discharged large quantities of pus, during which quinine and iron were freely given, but finally closed up entirely, without having had any connection whatever with the extremity of the stump, being confined to the middle third of the thigh. Had the amputation been performed above, doubtless we should have had troublesome sloughing, exposure of the bone, and perhaps re-amputation to perform. The abscess may have been accidental; but it is such an accident as might occur at any time.

There need be no hesitancy about performing this amputation, since statistics show the mortality to be less than in thigh operations.

Mt. Pleasant, Pa. ROBERT MCCONAUGHY, M.D.

News and Miscellany.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service. July 1, 1880, to September 30, 1880.

Bailhache, P. H., Surgeon. Relieved from temporary duty as medical officer Revenue B'k "S. P. Chase," and ordered to rejoin his station as member of the National Board of Health. August 26th, 1880. Detailed for duty as medical officer, port of Georgetown, D. C., during temporary absence of Passed Assistant Surgeon Fisher. September 17th, 1880.

Miller, T. W., Surgeon. Granted leave of absence for seven days, from July 17th, 1880. July 13th, 1880.

Gassaway, J. M., Passed Assistant Surgeon. Relieved from duty at Port Townsend, Wash. Ter., and ordered to report to Surgeon Fessenden, New York. July 7th, 1880. Granted leave of absence for thirty days from September 1st, 1880. August 9th, 1880.

Stoner, G. W., Passed Assistant Surgeon. Detailed as Recorder of Board for the physical examination of cadets of the Revenue Marine Service. July 6th, 1880.

Fisher, J. C., Passed Assistant Surgeon. To proceed to Elizabeth City and Edenton, N. C., as inspector. September 17th, 1880.

Goldsborough, C. B., Assistant Surgeon. Granted leave of absence for thirty-one days from August 26th 1880. August 13th, 1880.

Irwin, Fairfax, Assistant Surgeon. Granted leave of absence for twenty-one days from August 14th, 1880. August 2d, 1880.

Mead, F. W., Assistant Surgeon. Relieved from duty at San Francisco, Cal., and ordered to assume charge of the Service at Port Townsend, Wash. Ter. July 7th, 1880.

Cooke, H. P., Assistant Surgeon. Granted leave of absence for twenty days from November 23d, 1880. September 6th, 1880.

Guitéras, John, Assistant Surgeon. To report for temporary duty to Surgeon Sawtelle, St. Louis. July 7th, 1880. Relieved from temporary duty at St. Louis, and ordered to report to Surgeon Austin, New Orleans. September 28th, 1880.

Wheeler, W A., Assistant Surgeon. To report for temporary duty to Surgeon Fessenden, New York, July 7th, 1880.

Benson, J. A., Assistant Surgeon. To report for temporary duty to Assistant Surgeon Goldsborough, Baltimore. July 7th, 1880.

Banks, C. E., Assistant Surgeon. To report for duty to Surgeon Hebersmith, San Francisco. July 9th, 1880.

PROMOTIONS.

Godfrey, John, Passed Assistant Surgeon. Promoted to be Passed Assistant Surgeon, from July 1st, 1880. July 6th, 1880.

Brown, F. H., Passed Assistant Surgeon. Promoted to be Passed Assistant Surgeon, from July 1st, 1880. July 6th, 1880.

APPOINTMENTS.

The following candidates having passed the examination required by the Regulations, were appointed Assistant Surgeons, July 6th, 1880: John Guitéras, of Pennsylvania; William A. Wheeler, of Indiana; John A. Benson, of New Jersey; and Charles E. Banks, of Maine.

American Public Health Association.

The American Public Health Association will hold its Eighth Annual Meeting in New Orleans, commencing Tuesday, December 7th, 1880, and ending Friday, December 10th, 1880.

Papers will be presented on Abattoirs. Epidemics, Life Insurance in its relation to the Public Health, The Storm-water Question in City Sewerage, The Sanitary Engineering Problems of the Mississippi River, The Hygiene of Emigrant Ships, The Prevention of Venereal Diseases, Voluntary Sanitary Associations, etc.

The special questions suggested for discussion at this meeting in addition to those connected with the papers above referred to, relate to methods of preventing the spread within a town or city, after they have once been introduced, of such contagious or spreading diseases as diphtheria, scarlet fever, yellow fever, measles, smallpox, etc., and are as follows:

A.—What are the best means of securing prompt and reliable information as to the presence and location of cases of such disease?

B.—What are the best means of securing isolation of the first or of single cases of such diseases, and what are the chief difficulties in securing such isolation?

C.—Under what circumstances is it proper to declare such diseases epidemic in a place?

D.—Under what circumstances is it proper to recommend the closure of schools on account of the prevalence of such diseases?

E.—What precautions should be taken at the termination of each case as to—

a.—Care and disposal of the dead?

b.—Disinfection and cleansing of the room and house?

c.—Period of time at which it is safe to allow the convalescent to return to school or society?

Brief practical papers upon any or all of these

points are earnestly requested, and it is hoped that those attending the meetings will come prepared to give the results of their experience upon the questions, and to make positive recommendations.

Gentlemen who propose to present papers at this meeting are respectfully requested to notify the President or Secretary of their intentions and of the title of their papers, in order that they may be assigned a proper place in the programme.

The president is Dr. John S. Billings; the secretary, E. H. Janes, M.D., both of Washington, D. C.

The Bogus Diploma Business in Boston.

Even the immaculate Athens of America has been shown to have a diploma selling shop in its midst. Here again the exposure of the fraud is due to the daily press, the Boston *Herald* having drawn the veil which concealed these slippery transactions. The institution bore the name of "The New England University of Arts and Sciences," and the man at the helm was Dr. Henry C. Stickney. He had lived variously at Manchester, New Haven, Stowe, Vt., and Boston, Mass.; and the diplomas were dated at all these places. The incorporation of the university was in 1875, in New Hampshire, but the bill of incorporation was repealed the next year. The diplomas were signed by William Wancock D.D., President; D. M. Smith, M.D., Secretary; H. C. Stickney, M.D., E. Edgeworth, M.D., John Thompson, LL.D., A. Simons, M.A., and H. E. Hassgood, M.D. A comparison of names with those on the diplomas presented to the Illinois State Board of Health reveals considerable similarity, though there are names on one which are not on the other. "Wancock" is substituted for "Warwick," and there is quite a shifting of initials and Christian names. Stickney's and Smith's names are prefixed alike on both diplomas. Stickney is supposed to have turned out about one hundred doctors. The price of the diplomas ranged from $100 to $145. He was also connected with a similar college in Montpelier, Vt. He acknowledges, in the main, the charges made against him.

A "Hospital Day" in Philadelphia.

Last week there was held in this city a meeting of professional and business men, to inaugurate a movement by which a permanent non-sectarian association shall be formed in this city, to be known as the Hospital Association of Philadelphia. The object shall be the developing and perpetuating the observance, by each organized religious body, of a yearly Hospital Day, leaving each church free to indicate the special application of the funds raised by it, whether to one or more institutions named, or to a common fund, to be divided among all, according to such plan as may be deemed best.

Mr. William Gulager occupied the chair, and J. A. B. Williams acted as secretary. After addresses by J. W. White, A. H. Jones, Edward H. Hance, and others, resolutions were adopted proposing an organized effort for exciting a general interest in the work of providing for the sick poor, and authorizing the appointment of a committee of ten to confer with the officers of the different hospitals in the city, with pastors of churches, and with such others as the committee may think it wise to include, as to the best method of inaugurating a general Hospital Day, and who shall be empowered to take such steps as they shall judge will best promote the success of the movement. The committee to be appointed will call a general meeting for the purpose of furthering the proposed movement.

It may be added in this connection that by the will of G. W. J. Reune, a resident of Georgia, who died in this city some months ago, provision is made that in the event of the death of his wife and children his estate shall be devoted to the erection of a hospital for incurables in Philadelphia. The property is valued at $2,000,000.

OBITUARY.

—Dr. Addison Arthurs died recently, at his residence on Grant Street, Pittsburgh. He served for a number of terms in City Councils, and was for many years a member of the Board of Health, and director of the National Bank, of which his brother is president. Deceased was about fifty years of age and leaves a widow.

MARRIAGES.

CHAMBERLAIN—HEULINGS.—On September 16th, 1880, at the residence of the bride's parents, in Moorestown, N.J., by the Rev. H. Hastings Weld, William Chamberlain, M.D., and Miss Emma J. Heulings.

EGEE—LOUX.—On the evening of the 15th inst., at the residence of the bride's parents, by the Rev. John McCron, D.D., J. B. S. Egee, M.D., and Miss Anna M. Loux, all of this city.

GILFILLAN—LADD.—At St. Ann's on the Heights, October 21, 1880, by the Rev. P. H. Schenck, D.D., assisted by Rev. J. A. Gilfillan, William Gilfillan, M.D., and Miss Kate Ladd, all of Brooklyn.

LODER—ROSE.—On Thursday evening, September 23d, at the residence of the bride's parents, by the Rev. A. L Loder, St. Paul, Nebraska, brother of the groom, Dr. Percival E. Loder and Hannah, eldest daughter of Benj. F. Rose, all of this city.

LOUGHRIDGE—EDWARDS.—At Danville, Ky., on Wednesday morning, September 1st., by Rev. Dr. J. Edwards, Samuel O. Loughridge, Esq., M.D., of Peoria, Ill., and Miss Effie M. Edwards, daughter of the officiating minister.

DEATHS

BARTLETT.—On September 15th, Dr. Lloyd G. Bartlett, of No. 36 West 31st. st., New York, after a lingering and painful illness, of Bright's disease, at the residence of his sister, in the City of Binghamton, N. Y.

BLAKE.—In New York, suddenly, on Monday, September 27th, John Ellis Blake, M.D., in the forty ninth year of his age.

CURRAN.—At Asbury Park, N. J., on Sunday morning, September 19th, Dr. William Curran, in the seventy-eighth year of his age.

HILL.—Suddenly, at South Norwalk, Conn., September 18th, Dr. John Hill, son-in-law of the late Col. George Middlebrook, of Wilton, Conn.

NEWTON.—At his home in Sabathu, North India, July 29th, Rev. John Newton, Jr., M.D.

SIMPSON.—In San Francisco, August 10th John H. Simpson, M. D., son of the late Rev. John Simpson, of the Maine Conference, aged thirty-seven years.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1234] PHILADELPHIA, OCTOBER 23, 1880. [Vol. XLIII.—No. 17.

Original Department.

Lecture.

OTOLOGICAL AND OPHTHALMOLOGICAL CASES.

By M. F. Coomes, M D., Professor of Physiology, Ophthalmology and Otology in the Kentucky School of Medicine. Delivered before the Polytechnic Society, of Kentucky.

REPORTED BY A. H. KELCH, M.D.

Leonard M., aged fifty-two, consulted me August 6th, 1880, and gave the following history: About January 18th, 1880, he was seized at night with severe pain in the left ear. He sought medical advice, but obtained little or no relief. The pain continued severe for several days and then modified to some extent, but the hearing was materially impaired after the first few hours of the acute attack. In the course of a week it looked very much like a mastoid abscess, and became swollen and tender to the touch. This state of affairs gradually grew worse, the pain becoming excruciating. By the first of May the swelling was so great as to interfere with the movements of the neck and upper spinal column. He also experienced some difficulty in locomotion. In addition he became restless and unable to sleep; the appetite was likewise much impaired. These symptoms increased until he called on me, when I examined the external auditory canal and found it partially closed. The drum membrane was red and thickened to such an extent as to destroy almost every vestige of its normal appearance. The hearing power in the diseased ear was totally destroyed, except for transmitted sounds. The surface over the region of the mastoid process was red, swollen and tender. By careful manipulation fluctuation could be detected. This, however, I was not certain about, and Professor James M. Holloway was called in consultation, who, without hesitation, said that there was fluctuation present. This existed below and posterior to the mastoid process. It was decided to use the aspirator, the needle of which was introduced three times without obtaining pus. After failing in this attempt we were somewhat puzzled, fearing we had mistaken the nature of the case, and that it might, after all, be of an encephaloid character, although there were no symptoms of this affection except the duration. With these facts we determined to make an incision, and if no pus was found, subject a portion of the tissue to a microscopic examination. Placing the patient under the influence of chloroform the structures were laid open down to the mastoid process, which was in a carious condition. The incision was followed by free hemorrhage, mixed with what appeared to be a small quantity of bloody serum. With considerable difficulty the finger was forced through the upper part of the sterno-cleido mastoid muscle. As soon, however, as this was accomplished and the finger removed, a free flow of sanious pus occurred. This was very gratifying, as proving the non-existence of encephaloid, which in this locality would have been almost necessarily fatal. After the abscess was relieved of its contents a drainage tube was placed in the wound and a compress of borated cotton placed over it, to hold it in situ, and so arranged as to make proper pressure. The wound was dressed once a day, in the manner above described. The swelling rapidly disappeared, and the patient's general health improved very much.

August 14th the wound appeared almost free from pus, and promised a speedy closure. Aug. 15th, when the dressing was removed, I was astonished to find a free discharge. Pressure upward and forward evacuated about three or four drachms of pus that probably had been isolated from the main cavity. The sudden flow was probably due to the breaking down of the sac walls. After as complete evacuation as was possible a compress was so arranged as to keep constant pressure, leaving the main opening free. The dressing was thus arranged from day to day, until the 18th, when the swelling had nearly subsided and the wound was again in a condition almost ready to be closed.

August 18th he was permitted to return to his home, Breckenridge county, Ky., with the instruction to keep applied the antiseptic dressing previously mentioned. He was free from pain, had a good appetite, and expressed himself as feeling entirely comfortable.

Case 2.—Laura D., aged thirty-two, consulted me October 28th, 1878. At that time she was suffering from irido-cyclitis in both eyes. Posterior synechia existed in both eyes. Atropia dilated the pupil partially, the adhesions being numerous between the iris and the capsule of the lens on both sides. Three years previous to her visit she had suffered with what I presumed was specific iritis, as her history was that of an individual affected with inherited syphilis, having suffered from frequent attacks of what she termed sore eyes. Upon critical examination I found her vision much impaired, equaling in the left eye only about $\frac{20}{40}$, while in the right it did not exceed $\frac{20}{50}$. At this time she was also laboring under an attack of malarial fever, and I declined to operate upon her until her health could be improved. I ordered her twenty grains of quinine every other night, for three nights, which relieved her malarial complications. After this, tonics and the iodide of potassium were administered until her general health was so improved as to justify the operation, and I performed iridectomy upon both eyes, making rather a wide section at the superior portion of the cornea. After the operation a four-grain solution of atropia was dropped into the eyes every four hours until the acute inflammatory symptoms which followed the operation had subsided. All tenderness quickly passed away and her vision was very materially improved, so much so that by the aid of a proper glass she was enabled to read $\frac{20}{40}$ with the right and $\frac{20}{30}$ with the left eye.

Two years have now elapsed, and she has enjoyed perfect comfort, with good vision; whereas, the three years preceding the operation, her eyes had been a constant source of annoyance, disabling her from the performance of labor of any kind.

Case 3.—Miss M. called upon me in November, 1878, suffering from inflammation in the ciliary body of the right eye. Careful investigation revealed that the patient was laboring under tertiary syphilis. I at once prescribed full doses of the iodide of potassium, beginning with ten grains after each meal and at bedtime. Under this plan of treatment the symptoms manifested in the eye, and in fact all the specific manifestations, abated very rapidly; and in three weeks the woman was apparently well, with the exception of slight ciliary irritation and redness in the right eye. The iodide was persisted in for three weeks longer, with but little benefit. Feeling convinced that nothing short of the knife would relieve my patient, I performed an iridectomy upon the diseased eye. The after treatment in this case consisted in the application of atropia drops, and protecting the eye from the glare of strong light. Within ten days after the operation all evidence of irido-cyclitis had disappeared, and the patient was comfortable, and enjoying perfect vision in the organ that had been affected. She has had no return of the difficulty up to the present time, thus affording another instance of the great and permanent relief in store for such cases, by the use of the knife.

Case 4.—Mr. L., aged 22; printer by trade; consulted me in September, 1877. I found inflammation of the ciliary body of the left eye. He denied ever having acquired syphilis, but the manifestations were so marked that I felt confident he was suffering from the action of syphilitic poison, and therefore prescribed accordingly. Under the free use of iodide of potassium his cyclitis abated, only to return when the medicine was discontinued. He begged me not to use the knife if it could be avoided. I yielded to his wishes, and during one of his recurrent attacks he had an altercation with a companion, who fractured his walking stick over Mr. L.'s nose. Free hemorrhage occurred at the time, from the bruised organ. For some reason, the iodide he had been taking was discontinued from the day on which he received the blow. To my surprise, as the effects of the blow disappeared, so did the irido-cyclitis. Relief seemed to be permanent; that is, all irritation had apparently subsided and vision was perfect in that eye. This state of things lasted about eight weeks only, when the symptoms were renewed. He now positively refused to permit me to use the knife,

and six months subsequently he was suffering with the eye quite as much as when I first saw him. Indeed, he was almost blind, and scarcely able to make his way with the diseased eye. The course of this case is similar to many that might be mentioned, constitutional remedies being capable of resisting or modifying the disease for a time, but not of sufficient power to effect a perfect cure. Just how much the blow upon the nose influenced the disease at the time is more than I can say; at all events it did abate and remain quiescent for the length of time above mentioned. Possibly the counter irritation caused by the blow had something to do with the arrest of progress of the disease.

Communications.

ON QUININE IN FEVERS AND DISORDERS ACCOMPANYING THEM.

BY E. T. BLACKWELL, M.D.,
Of Hackettstown, N. J.

Our opinions of the physiological action of the cinchona salts are much more definite and philosophical than were those of our fathers. Yet, so great has been our reverence for their authority, and so powerful the force of habit, that we have found it difficult to depart from the beaten track of therapeutical belief.

Having anticipated, by many years, the new doctrines concerning quinine, of which there is a brief record in the Transactions of the Medical Society of New Jersey, for the year 1863, I think it well to indicate the degrees by which my faith in the new departure became settled and fixed.

During several years previous to the publication of the note referred to, I made quinine a leading remedy in inflammatory fever, using it thus in the winter of 1852–53, in puerperal peritonitis; while early in 1854 I employed it in typhoid fever, alike in exacerbation and remission, against the judgment of an excellent practitioner, many years my senior, who would only sanction it in the brief interval of perspiration.

In the spring of 1862 there occurred to me a case, presenting, with a continuous fever, a slight dry cough, and a minute crepitant râle. The patient had also an impatient and irritable temper; but this I thought to be the natural disposition. As there were no characteristic or distinctly pathognomonic symptoms, I fixed upon the bronchitis as the exciting cause of the fever; wondering, however, that an agency apparently so slight could produce so determined pyrexia. The disease lasted about six weeks, when another member of the family took it, with an additional symptom, diarrhœa. The mother, who had watched assiduously over the two preceding, became the next victim, a new sign being developed, that of deafness. Long before this I had recognized the disorder as continued or typhoid fever, and as the treatment instituted while the disease was undetermined had been satisfactory, it was continued in the cases subsequently occurring in the family, to the number of eight, all of whom recovered. The manner of its administration is thus epitomized in the report aforementioned.

"The treatment was quinine to cinchonism, two grains in compound infusion of bark every two hours; ipecac. and opium, if there was not much congestion. This treatment would generally reduce the pulse daily; in males about eighty-four beats were reached, or in females one hundred per minute. * * * * The duration of the disease under this treatment was from ten days to two or three weeks; the whole number of cases treated was not less than thirty, the deaths three."

By reference to my books, I find the amount of quinine, as stated above, much less than the maximum exhibited, there being one prescription of one drachm to be divided into twelve powders; also, that convalescence did not occur until six and four weeks respectively, in the first and third cases, but sooner in others.

The cases here reported are suggestive of the beneficial action of the remedy in diseases presenting indications that may be wrongfully interpreted by a careless observer.

January 22d, 1879. Mrs. H. W. S. has had a chill, followed by fever and severe pain in the region of the liver, the skin being elevated in wheals by urticaria. Laxative doses of calomel, with citrate of potash mixture, were employed during the first two days of treatment, after which full doses of quinine were given, the symptoms all disappearing with the fever. Subsequent attacks of a like character, in the late summer and autumn, were treated in the same way, with good results.

July 5th, 1880. T. H. has tenderness of the scalp and inflammation of the left eye, which is particularly painful during the night. He has also tenderness of the liver, and a pain in the top of the right shoulder. There is also fever, of which he had a paroxysm on July 3d. A former attendant, who discerned only the intense suffering in the eye, directed his attention alone to that organ, treating it by instillation of nitrate of silver, but ineffectually. I gave him half-drachm doses of iodide of potassium, in one pint of water, in the morning, fasting, as directed by

Dr. Guiteras, in the Philadelphia *Medical Times*, vol. x, page 446. This for the liver. Through the remainder of the day he had liberal doses of quinidiæ sulphas, with opium.

July 7th. Had pain in the head during the past night, but the inflammation and pain in the eye are less; the tongue is coated but moist; the urine is free and the appetite improved. The treatment to be continued as before, a weak ointment of calomel and lead cerate being applied to the eye. On July 10th he was so far recovered as to be discharged, taking only a cinchona tonic.

August 24th, 1880, I was called to visit Willie F., aged two and a half years, who had a convulsion, attended by a paroxysm of fever, which had caused it. I ascertained that he had previously had convulsions at changing intervals, and that each was accompanied by fever. He had also a diarrhœa of two weeks' duration, which had followed the administration of calomel by my predecessor in the case.

He was placed upon the following:—

℞. Quinidiæ sulph., grs. viij
Liq. ferri persulph.,
Ol. gaultheriæ, āā gtt. iv
Aquæ creasoti,
Tinct. opii, āā ♏ xij
Ext. glycyrrhizæ, fl. ʒ j
Aquæ, ʒ ij. M.

Sig.—A teaspoonful to be given every three hours.

℞. Bismuth. subcarb., ʒ j
Pulv. acaciæ, ʒ ss
Glycerinæ, ʒ ss
Aquæ, ʒ iss. M.

Sig.—A teaspoonful to be given every three hours, the two to alternate.

August 26th. Has had no fever, except on the evening of the 24th, his pulse now marking 110. He had three evacuations of the bowels yesterday. The treatment to be continued.

September 7th. Having had the quinidia and ferric sulphate every three hours, with an additional amount once a week to meet an anticipated septenary recurrence, has remained free of fever, convulsion or diarrhœa.

September 19th. Nearly four weeks have now elapsed since the last fever and convulsion, and, as the treatment is to be maintained, I have no fear of their return.

Thus I have shown, I think, how the cinchona salts may be very salutary, if scientifically applied, in conditions apparently quite different. A late letter-writer affects to stumble at the very numerous indications which are met by this medicine, some of which are concealed from the novice, and is pleased to suggest that it is prescribed thoughtlessly, and without due regard to circumstances which have been believed to contraindicate its employment; quoting, in support, the late Dr. Wood, whose views on the methods of using quinine, though quite abreast of the knowledge of his time, are now mostly obsolete.

Quinine is a power for good, in the hands of those who rightly read the phenomena of disease and intelligently adapt it to meet varying indications; a knowledge that does not come by intuition, but is the outcome of extended observation and profound thought. When we reflect how powerless were our fathers in pernicious intermittents and other disorders of zymotic origin, we may congratulate ourselves that science has presented to us a medicine of matchless achievements, and of incalculable value to the human race.

EARLY EXCISION IN CASES OF RECTAL CANCER.

BY JOHN B. ROBERTS, M.D.,

Lecturer on Anatomy and on Operative Surgery in the Philadelphia School of Anatomy.

In the Reporter of June 9th, 1877, I presented a paper on "Excision of the Lower End of the Rectum in Cases of Cancer," in which, besides giving the history, method and results of the operation, I detailed a case that had been operated on by Dr. R. J. Levis, in the Pennsylvania Hospital. The patient made a rapid recovery, and returned to his home relieved of the distressing symptoms for which he had come to the city for treatment. As the paper referred to attracted considerable attention, on account of the comparative novelty of the procedure, and seemed to lead to the operation being more frequently employed, and earlier resorted to in the disease, I have determined to give the history of the patient subsequent to his return home. For this I am indebted to Dr. James Davison, of Canton, Pa., who had charge of the case during a considerable period of time.

A reference to the Reporter of the date mentioned will show that the man, aged sixty years, was subjected, on January 6th, 1877, to excision of three inches of the lower extremity of the rectum, for the removal of an epitheliomatous growth of the duration of a year or more. After the operation the patient reacted perfectly, had little fever, almost no pain, and rapidly convalesced. When I examined him during February his condition was exceedingly satisfactory. An

examination of the parts showed some contraction at the anus, as would be expected from the cicatricial nature of that orifice ; and from the anus to the lower end of the gut the cavity was lined with what had the appearance of mucous membrane. When the finger was introduced, it at times passed into a sort of cul de sac alongside of the inferior end of the rectum, but there was no difficulty in passing directly into the bowel.

The man had habitual constipation, and was obliged to have continual resort to laxatives, to keep the fæces from being retained too long, for then the hardened masses gave pain when expelled. To accomplish this he used compound rhubarb pills, according to indications, and occasionally employed enemata of soap and water ; by this means he had a passage every few days. If the contents of the bowels were very loose after an active purgative, he was apt to soil his clothes, but otherwise he had perfect control of defecation, and even seemed to exercise slight control over the escape of flatus.

When he reached home, in March, 1877, he was greatly relieved, but soon stinging, lancinating pain in the rectum recurred ; and, at the end of April, hard nodules presented themselves near the outlet of the bowel, in the region of the cicatrix left by the operation. The disease soon made rapid progress, and by summer secondary deposits had occurred in the inguinal glands, and as Dr. Davidson believed, in the mesenteric glands as well. After this time he grew rapidly worse, had a great deal of tympanitic distention of the bowels, and at one time passed suddenly a large quantity of purulent fluid. The tympany then diminished, but fistulous tracts developed in the sacral region, especially on the right side, which continued to discharge large amounts of pus, until the date of his death. He died on September 8th, 1877, eight months after the operation, which had evidently prolonged life, though the patient's suffering during the latter part of the spring and summer was very great, and only ameliorated by large doses of morphia. No autopsy was made.

This history shows what was stated in my original article, that excision of the rectal disease is to be looked upon as a palliative operation, destined to postpone the fatal result of the disease, but not to eradicate it permanently, unless undertaken at the earliest manifestation of abnormal growth. As is well known, the form of malignant disease usually found in this region is less virulent than many varieties of carcinoma and sarcoma ; hence, immediate resort to removal is the only true method of treatment. For many years professional advice has generally been to allow all cases of rectal cancer to pursue their onward career untreated, until occlusion of the intestine demanded colotomy as a last resort. A study of recent literature will prove to the reader the necessity of excising the first nodules of malignant character that are found about the anal aperture. At times the growth has its primary seat in the bowel, several inches above the anus, or the case is not subjected to professional inspection until it has existed for many months. In such instances operative interference may not be justifiable ; and there are, as I know from examination of numerous cases, many patients suffering with rectal cancer who should not be subjected to excision of the rectum. In cases, however, seen early and where the disease is limited to the anal region or to the adjacent section of the rectum, excision at once offers the only hope of relief. The recent elaborate observations of my friend, Mr. Cripps, of St. Bartholomew's Hospital, London, and the numerous cases of Van Buren and Keyes, of New York, taken in conjunction with many isolated cases reported during the past three years, prove the acceptability of the operation to the profession, and its value in properly chosen cases.

In this connection I wish to briefly record three operations of this kind performed by Dr. Levis, since the publication of the case whose subsequent history has just been given. One was a woman living in New Jersey, about thirty-five years old, who had suffered a long time with cancerous disease. The case was considered by Dr. Levis and myself as suitable for operation, especially as the growth is more superficial in the female, on account of the proximity of the vagina. The vaginal wall in this case was not infilliated by the growth. The operation was done in the ordinary way, but for some unknown cause the woman failed to react, and died two or three days later.

A successful case from Maryland presents the following history, which I have obtained from Dr. H. Augustus Wilson. The patient, a man aged forty-five years, had suffered with rectal disease for one year, which was supposed to be hemorrhoids and rectal ulcer, until a short time before he came to Philadelphia. By tenesmic efforts a mass of diseased mucous membrane was protruded from the anal aperture, resembling prolapse of the bowel. He suffered great pain. The forefinger introduced into the bowel could just reach the upper limit of the disease.

On July 6th, 1880, Dr. Levis removed the

lower end of the rectum by enucleation. The man reacted well; his temperature never touched a higher point than 102°.8; and on the sixth day defecation occurred for the first time, and with but little pain. He was discharged on September 7th, 1880, entirely relieved, and having scarcely any distress from the time of operation. The growth was determined, by microscopical examination, to be epithelioma. It is, of course, probable that the disease will return; but the slight inconvenience which the man experienced from the operation justified the attempt to give him a period, more or less extended, of relief from the agonizing pain which he previously suffered.

The only instance in which any trouble whatever occurred through hemorrhage, was that of a medical man from New England, who desired to have the carcinomatous growth removed by excision. His health had been a good deal undermined by the continuance of the painful disease, and his condition was not looked upon as very favorable. The operation was performed, and hemorrhage prevented in the usual way; and for a few days the patient did tolerably well, though he seemed depressed. During one night, however, secondary hemorrhage occurred, which seems, from the statements of the attendants, to have been quite profuse. The cavity was securely plugged by means of rags and a dilating speculum, but hemorrhage afterwards recurred and the patient sunk exhausted.

Medical Societies.

THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

At the meeting of the College of Physicians, held April 7th, 1880, James H. Hutchinson, M.D., brought before the College, in order to give the Fellows an opportunity of personally examining it, a case of

General Hyperostosis.

Before introducing the patient, he read the history of the case, which had been prepared from notes taken at the bedside by Dr. Joseph M. Fox.:—

J. S., aged 21, born in Pennsylvania, unmarried, a newspaper carrier, was admitted into the men's medical ward of the Pennsylvania Hospital, March 17th, 1880. He is the oldest of a large family of children, all of whom are living except two, who died young, of diseases incident to infancy. His father died some years ago, his death having been apparently hastened by an accident from which he never recovered. His mother is alive and in good health. There is no history of syphilis or of any other hereditary disease in either parent. The patient himself does not present any of the usual evidences of congenital or acquired syphilis, his teeth particularly being well formed.

Up to the age of three and a half years his health seems to have been ordinarily good. At this time, however, he had a series of convulsions, which lasted for about two weeks, and which came on apparently without exciting cause of any kind. After one of these convulsions, it was observed that he had very little motion in the shoulder-joints and in the left elbow-joint; and a physician who was consulted said that one of his shoulders was dislocated, which one he does not know.' Since then there has been, he says, little alteration in the condition of his shoulder-joints, but that the difficulty in moving the elbow has steadily increased, until this joint is now rigidly anchylosed. There would seem to have been no further increase in his disease until he had attained his eleventh year, when his left knee suddenly began to swell, and continued swollen for some days. After the subsidence of the swelling, motion in it was found to be very much impaired. Subsequently, however, some of the lost motion was regained.

Six years later the right side of the patient's face was attacked in the same way, and, although the swelling lasted but a few days, he has ever since been unable to fully open his mouth. Three years ago the disease reappeared in the left knee, and a year later it had also involved the right. Both of these joints have ever since remained stiff, the amount of motion in either joint being exceedingly slight. He has also partial anchylosis of the hips, but is unable to say at what time this occurred, although it exists to a sufficient degree to prevent him from sitting down, and to interfere with progression. He can also give very little information as to the time when numerous exostoses on different parts of his body, which will be more particularly described hereafter, were first noticed, or as to the manner of their occurrence.

On admission, the patient's right arm and forearm are found to be swollen, the swelling being very tense, but unaccompanied by much redness or tenderness. He says that this swelling began about six weeks before coming under observation, and that it closely resembles in character others which have occurred at different times, and which have almost invariably been followed at a longer or shorter interval of time by thickening of the bone, or by an exostosis on the shaft of one of the long bones. He is free from fever, and is sure that during the previous attacks fever was never a prominent symptom. He can assign no cause for these attacks; they cannot be traced to exposure, to privation, or to constitutional syphilis. In all other respects his health would appear to have been more than ordinarily good, for he asserts most positively that, with the exception of the occasion already referred to in these notes, when it was thought his shoulder was dislocated, he has never been under the care of a physician, or even been seen by one professionally. His digestive functions are well performed; his lungs and heart are free from disease, the faint systolic murmur which is heard over the heart being unquestionably of hæmic origin. He does not

suffer from headache, and presents no symptom indicative of the existence of disease of the nervous system. There have, moreover, never been any return of the convulsive seizures. He is anæmic, but not to a marked degree.

The patient seems to be of fair natural intelligence, but is uneducated. In spite of the condition of the joints of the lower extremities, which prevents him absolutely from sitting down, he is able to earn his livelihood by selling newspapers, and finds no difficulty in keeping up in walking with his friends, or, as he expresses it, he "can walk with almost any one." He is unable, however, to get out of bed without assistance, but says he could do so if the bed were higher. In getting into bed, he throws himself on it with his face downward, and then gradually rolls over on his back, managing while doing this to bring his legs on to the bed.

A cyrtometric tracing taken by Dr. Louis Starr, which was exhibited, showed great deformity of the thorax, the left side protruding in front and the right in the back; the measurement on the latter side being thirteen and seven-eighths inches, and the former thirteen and five-eighths inches. There is very little movement of the chest during respiration, the difference in circumference during a full inspiration and after a full expiration being only three-quarters of an inch.

There is an exostosis about the size of a filbert on the inferior border of the lower jaw, one inch to the left of the median line. The jaws are almost completely anchylosed, and consequently the patient is unable to open his mouth more than half an inch.

A bridge of bone, probably consisting of exostoses fused together, extends from the fourth rib, along the lower margin of the left pectoralis major, upward toward the axilla. Two well-marked spinous exostoses start from the margin of the left glenoid cavity, and follow the anterior and posterior folds of the axilla outward, all the way to the insertions of the pectoralis major and the latissimus dorsi muscles into the lips of the bicipital groove; these processes are not continuous with the edges of the bicipital groove, for there is slight motion of the arm, although they touch the humerus. The left elbow is rigidly anchylosed in the extended position; the head of the left radius, however, rotates when the forearm is pronated and supinated. This condition of the elbow would seem to indicate that the loss of motion between the ulna and humerus is due rather to the presence of exostoses attached to the epiphyses of these bones, near the margin of the articulating surfaces, than to disease of the joint itself. The forearm, wrist, and hand of the left side are free from exostoses; hence there is no loss of function of these parts.

There is limited motion in the right shoulder. There is a well-marked exostosis connected with the posterior margin of the right bicipital groove, but no other osseous growths can be found on the right humerus; the right elbow is flexed at a right angle. On the anterior face of the right radius there is a large exostosis extending from the tubercle downward and obliquely outward, in the line of origin of the flexor digitorum sublimis muscle, to the insertion of the pronator radii teres; the presence of this large exostosis interferes with pronation and supination of the forearm. The right hand cannot be extended beyond the longitudinal axis of the forearm, although there is no interference with the flexion of this member. On the posterior surface of the right chest a line of exostoses begins at the inferior angle of the scapula and extends down to the inferior margin of the thorax; these bony masses are imbricated, and are attached to the ribs just in advance of the angles. The front surface of the chest on the right side is depressed, and there is some lateral deviation of the spinal column. The condition of the thorax admits of very little movement in respiration; hence breathing is principally abdominal. All parts of the scapulæ, save in the immediate vicinity of the glenoid cavities, are normal.

The transverse processes of the lumbar vertebræ are somewhat enlarged. There is very little motion in any portion of the spinal column. The spine of the right pubis is a little larger than normal; the skeleton of the pelvis in all other parts seems to be unaffected.

A thin plate of bone, an inch and a half long, and an inch and a quarter wide at its base, is imbedded in the proximal extremity of the left gracilis muscle; the broader end of this piece of bone is closely applied but not attached to the descending ramus of the pubis, and the other end terminates in a dense cord that is lost in the gracilis muscle. The branch of the linea aspera that starts at the trochanter major of the left femur is studded with bony prominences; there is also a small exostosis on the inner side of the lower epiphysis of the femur, at the edge of the articular cartilage. Small exostoses are attached to the articular margin of the posterior surface of the head of the left tibia. A large exostosis, terminating in a long spine, arises apparently from the posterior surface of the left tibia, in the line of origin of the inner head of the soleus muscle.

On the inner side of the left foot, where the tendon of the tibialis anticus is inserted, there are two small exostoses; one of these is on the internal cuneiform bone, the other on the proximal end of the first metatarsal bone; the same condition exists in the right foot. There is no impairment of motion in either ankle or foot. On the anterior and outer aspect of the right femur, near the middle, there is a large, oval, bony mass, four and a half inches long by two and a half inches wide; another, much smaller in size, is attached to the outer margin of the external condyle, in the line of the tendon of the biceps muscle. In other respects the right femur does not differ from the left, as already described. A small exostosis is seated on the spine of the right tibia, just below the junction of the upper and middle thirds; there is another small one on the external malleolus. The right lower extremity, in consequence of a twist in the pelvis, is apparently about one inch longer than the left; but careful measurements from the summits of the trochanters show that there is no actual difference in the length of the lower limbs. Motion in the hip and knee of both sides is greatly restricted, hence the patient is unable to sit down, although he walks fairly well.

In the absence of definite indications for treat-

ment, the patient was placed upon ten grains of the iodide of potassium three times a day. He was discharged, March 30th, at his own request. Apparently under the influence of the iodide, the swelling of the arm and forearm had decidedly diminished, the outlines of the humerus being distinctly traced and the radius and ulna easily felt.

NOTE.—When the patient was brought before the College (April 7th, 1880), a still further reduction in the amount of swelling of the right elbow had taken place. Indeed, the change was so great as to make it doubtful whether the improvement which had previously occurred could be rightly attributed to the treatment, since it had continued after he had left the hospital, and after he had ceased to take the iodide. It may have been, therefore, simply a part of the natural course of the disease.

At the meeting held May the 5th, 1880, the following paper, on

Foot-Binding in Ningpo, China,

being a supplement to a paper read December 3, 1879, was read by Robert P. Harris, A.M., M.D.

In my general paper on this subject, for the Empire as a whole, I stated that it was an error to suppose that the process was commenced in infancy, as had been claimed by travelers, and that I had never heard of its having been done in any part of China at an earlier age than five years. I also gave reasons for its not being commenced in infancy, as stated by the Chinese.

It having been reported, upon reliable authority, that the ladies of Ningpo had the smallest dwarfed feet in the Empire, some of them measuring but three and a half inches from heel to toe, I thought it not impossible that the practice might be commenced exceptionally early in that city, and therefore wrote a letter of inquiry to a lady who has been residing there for several years, and who has every advantage for obtaining the truth. This letter was arranged as a series of questions, twenty-one in number, all of which have been very satisfactorily answered in a reply received April 26th, 1880.

After my letter was sent to Ningpo, I accidentally met a female missionary, who had been several months in a school in Ningpo, but had been obliged to return home on account of failing health. Her statements caused me to append a note to my first paper (page 16), to the effect that the habit of Ningpo mothers was to bind their children's feet in infancy. This statement, like those of many travelers not understanding the Chinese tongue, was not correct. No doubt this lady had seen infants with their feet bound up, but they were not bandaged, as in the deforming process.

I will give the statements of Mrs. Butler, who has been highly commended to me as a perfectly reliable authority:—

"Among the wealthy of Ningpo the binding process commences at six or seven years of age. When a child is large for her age, its feet are first bandaged when five years old. No child has its feet bound at an earlier age than five.

"The smallest feet in Ningpo measure, as I had stated, three and a half inches in length. This is taken from the foot with its bandage on, and not from the shoe worn. The feet range from this length to seven inches, the average being about five inches. There is at Ningpo a mild form of compression which only includes the toes; the direction of the heel is not changed. Some of this class wear the smallest-sized shoe; this is accomplished by placing a heel of wood inside the shoe and letting the foot rest upon the heel, the heel of the foot being raised above the top of the shoe and covered by the pantalet. This form is not admired, as it is easy to detect the raised heel.

"Dwarfed feet are universal at Ningpo, all women having compressed feet, whatever their employment may be. It produces no caste distinction, and does not force upon them a life of shame, as there are many ways by which a living can be made, even with small feet.

"They bind their feet simply because it is the custom; it is not the least interwoven with their religion.

"Children are never born with feet like those dwarfed by the Chinese. They do not admire club feet as we see them from natural deformity; they consider that to be born with club feet is a great calamity.

"The Chinese themselves do not consider that binding the feet affects their health or spirits; and as there is no class of women in Ningpo with large feet, so that we could make a comparison, it is difficult to say whether the practice affects the health or not.

"The compressed feet suffer from cold; children are often quite lame from its effects. The feet are subject to corns and partial mortification, but are not lost by gangrene.

"If the feet are well cared for, the girl ceases to suffer at the age of thirteen or fourteen years. Occasionally one is known to be a sufferer all her life.

"The Chinese do not admire the sight of a bare, dwarfed foot, but regard it as disgusting. The girls like to show their feet when dressed, and their dresses are made to expose the shoe. They do not like any one to see their bare feet, not even the members of their own family. I have never met a Ningpo woman who would be willing to have her unbound foot exposed."

I wrote to Mrs. Butler to know if it would be possible to procure a photograph of a small Ningpo foot, but she answered that it would not. I wanted Dr. Carrow to get me a cast of a leg and foot together, but he failed to obtain one. Many very poor women could not be hired with a high price to allow a cast of a foot to be taken. A bare foot is longer and fuller than one under the bandage.

The wealthy, as a rule, have smaller feet than the poor, and the men have smaller feet than those of Europeans. It appears, then, from reports received from three different parts of China, that there is very little difference in this peculiar custom in Canton, Shanghai, Swatow and Ningpo; that the Chinese are wedded to it, but why, except that it is an old fashion, they do not know; and that it is not begun anywhere until after the child is old enough to have learned to walk; the age among the better classes being from five to seven years.

BRITISH MEDICAL ASSOCIATION.

(*Continued from p.* 344.)

In the Section of Pathology, Mr. Jonathan Hutchinson (London) opened the discussion on

The Influence of Injuries and Morbid Conditions of the Nervous System on Nutrition.

He said that it appeared that, while some held that the phenomena under consideration were to be explained by reference to the functions of the vaso-motor nerves, others taught that the nervous system had a direct control over nutrition, in addition to that which it exerted by regulating the supply of blood; and an advanced section of this school (with Samuel) recognized the existence of special trophic nerves. His object would be to try how far the phenomena of disease, which had been believed to support a theory of the direct influence of the nervous system upon nutrition, might be explained in other ways. Among the facts which seemed to discredit the hypothesis of the trophic nerves, and of direct trophic influence as a nerve function, were the following: the great rarity of some of the diseases supposed to illustrate it; the very peculiar features of some of them; their remarkable difference one from another; the close resemblance between most of them and certain other diseases which there was no reason to suspect of being of neurotic origin. Among the principal disorders which had been supposed to be due to nerve influence, were bed-sores and cystitis in the paralyzed; ulceration of the cornea in paralysis of the fifth nerve; sympathetic ophthalmia and neurotic iritis; herpes zoster and other forms of herpes; glossy skin after injuries to nerves; arthritis after spinal disease or injury; digiti mortui and "symmetrical gangrene of the extremities;" morphœa and allied forms of scleriasis cutis; disorganization of joints in locomotor ataxy; brittle bones and osteomalacia in the insane and in disorders of the nervous system; disturbances of nutrition of the skin and bones in leprosy. Reasons were given for doubting that the nerves had a direct power in the production of these conditions by an influence transmitted to the periphery, without reference to the blood-supply. The discussion which followed was participated in by Drs. Brown-Séquard, Buzzard, Allbutt, Wilks and Dickinson.

D. G. Hamilton, M.B., F.R.C.S., Ed. (Edinburgh), presented a brief résumé of

Pathological Researches on Tubercle and Allied Affections of the Lung.

His remarks were mainly confined to an explanation of the preparations he exhibited, bearing upon a series of articles published in the *Practitioner* during the last two years. The following is a brief synopsis of some of the results obtained in his researches on the above subjects. 1. Tubercle of the lung is always the result of irritation of an endothelium by a peculiar chemical agent, probably a ferment, produced in the softening of a caseous mass. 2 The source of this caseous infection may be situated in any tissue. 3. Tubercle may be primary or secondary in the lung. By primary tubercle of the lung is meant a disease in which the tubercle forms the first and only lesion, the caseous source of infection being situated in some distant organ or tissue. By secondary tubercle is meant a disease in which the caseous deposit is the primary disease in the lung, and where the tubercle is of secondary occurrence. 4. In the primary form the caseous ferment is brought to the lung from some distant part by the blood vessels, and the tissue first irritated by it is the endothelium of the alveolar capillaries. In the secondary form of the disease the lymphatics absorb the caseous irritant, and it is from their endothelium that the tubercle originates. 5. A tubercle, wherever it exists, is invariably composed, when fully developed, of the following parts: (*a*) one or more giant cells; (*b*) a reticulum formed by processes given off from the sides of the giant cell, on which nuclei lie as on any connective tissue; (*c*) a peripheral capsule. 6. The giant cell represents an over-developed connective tissue corpuscle. The processes correspond with an attempt on its part to throw out an organized periplast. 7. The action of the irritant, which gives rise to the abnormal activity of the blood-vascular or lymphatic endothelium, is apparently evanescent, and when its energy is expended the whole of the structures composing the tubercle develop into fibrous tissue. By so doing, if the subject overlive the acute attack, a cirrhosis of the lung or other organ is frequently induced. 8. The commonest cause of the primary form is the softening of the caseous gland. That of the secondary is chiefly either a caseous catarrhal pneumonia, or a chronic interstitial pneumonia, with bronchi-ectatic cavities containing caseous debris. 9. Tubercle, especially the secondary form, is a commoner disease of the lung in adults than in children or youth. The primary form is oftener met with in childhood. 10. Catarrhal pneumonia passes through three stages. The first is the acute or subacute, in which the alveolar epithelium proliferates. The second is the stage of caseation, in which the elements so formed, and which have accumulated in the air vesicles, caseate. The third is the stage of excavation, in which the necrotic caseous matter softens and forms cavities. 11. The softening is a purely chemical process. 12. Small tubercles are commonly found in the neighborhood of the cavities; but they are usually invisible to the naked eye, the bodies pointed out as tubercles being isolated catarrhal pneumonic nodules. 13. The development of tubercles in such a part has very little to do with its disintegration. They rather tend, by their fibrous organization, to induce cicatrization. 14. There is no such thing as "tubercular phthisis," in the sense of a primary tuberculous deposit leading to destruction of the lung substance by softening and excavation of the individual tubercles. They certainly caseate in the centre; but as soon as resolution occurs in the caseous part the resulting debris is absorbed, and the capsule at the periphery contracts so as to obliterate the cavity. 15. Secondary tubercle of the lung is frequently associated with bronchiectasy. The bronchi-ectatic cavities are apt to be mistaken for those formed by destruction of the lung-tissue, or true phthisical excavations. 16. There is a form of

catarrhal pneumonia in which the caseous nodules are distributed universally throughout the whole lung, and which is very apt to be mistaken for tubercle. It is not uncommon, and generally occurs in children.

In the section of Ophthalmology Mr. Priestley Smith (Birmingham), opened a discussion on

Glaucoma.

by stating that the fundamental and essential cause of primary glaucoma was stated to be an abnormality situated within the eye itself, viz., an insufficiency of space between the ciliary processes and the lens. All conditions which tended to promote venous turgescence, arterial hyperæmia, or increased secretion within the eye, might become exciting causes of glaucoma, provided this abnormality were present. The outline of the argument was as follows: The intraocular fluid escaped from the interior of the eye at the angle of the anterior chamber. In glaucoma this angle was compressed or closed; hence the excess of fluid within the eye, and the increase of tension. Experiment showed that when the vitreous pressure was raised slightly above the aqueous pressure, the ciliary processes were driven forward against the periphery of the iris, and the angle of the anterior chamber was closed thereby, precisely as in glaucoma. This suggested that the starting point of glaucoma was some condition which raised the vitreous pressure slightly above the aqueous pressure. In health a current of fluid passed constantly from the vitreous to the aqueous chamber, through the "circumlental space," that is, the space which separated the margin of the lens from the ciliary processes. Narrowing of the circumlental space would tend to raise the vitreous pressure. Circumstantial evidence favored the idea that narrowing of the circumlental space was actually the starting point of primary glaucoma. The examination made recently of a series of healthy and glaucomatous eyes had lent support to the foregoing theory, by showing (*a*) that in the healthy eye the diameter of the lens increased with age; (*b*) that this increase was accompanied by a diminution of the circumlental space; (*c*) that in certain stages of glaucoma the circumlental space was, as a fact, abnormally narrow. Measurements in three cases tended to show that the lens of the glaucomatous eye had a greater diameter than the lens of the healthy eye at the same period of life. These, however, justified no general conclusion as to whether the abnormality of the circumlental space depended primarily upon the size of the lens, or upon the situation of the ciliary processes.

Dr. Brailey (London) said that the increase of the lens with age, was unproved; and that he had not found it increased in glaucomatous eyes, frozen in a delicate membrane directly after excision. The same appeared to be the case in many sections of eyes figured by Becker, Knies and Pagenstecher. Dr. Brailey further stated, that the ciliary processes were atrophied in all the primary glaucomatous eyes he had examined; that they were extra large, with diminshed tension, and that they, therefore, were not the cause of the iris periphery being advanced. He was also of opinion that their atrophy was not due to pressure, for in iritis serosa, or keratitis punctata, or aquocapsulitis, all appearing to be to some extent synonymous, the ciliary processes were of good size, though the anterior chamber was extra deep. Dr. Brailey then referred to his paper, "On the Size of the Aqueous Chamber in Glaucoma," and expressed the opinion that, in atrophy of the ciliary body, and especially of the ligamentum pectinatum, part of it approximated the iris periphery to the cornea; or the ligamentum pectinatum gave origin, by its innermost stratum on the one hand, to the connective tissue fibres of the iris; and, on the other, was connected, through the open meshwork leading to the canal of Schlemm, with Descemet's membrane. He explained, that the operation of sclerotomy cut through this contracting band, and allowed the base of the iris to recede from the cornea; that of iridectomy prevented mischief by removing the base of the iris; and that of hyposcleral cyclotomy cut through the ciliary body, and made a new approach to the canal of Schlemm. The atrophy of the ciliary body in old persons was accompanied with the development of dense connective tissue in it, and was, Dr. Brailey believed, in nearly all cases the result of an inflammation, which, however, was generally but slight.

Mr. Cowell (London) pointed out the impossibility of any one theory of glaucoma being sufficient to explain all cases of the disease. He believed that there were many causes, mechanical, nervous and nutritive, of the loss of balance between secretion and absorption within the eye, and the resulting increased tension; and alluded to the analogy of this loss of balance in other cavities of the body. He accepted many of the recent theories as applicable to various cases, and believed that future work would be more valuable if we ceased to expect to find any theory to explain all cases of the disease. With regard to treatment, he thought that in most cases iridectomy was the best and most successful, and endeavored to point out some of the causes of the unpopularity of the operation.

Dr. Andrew (Shrewsbury) asked, as glaucoma could undoubtedly take place in an eye in which the lens was absent, how Mr. Priestley Smith would then explain the theory brought forward by him.

Professor Donders (Utrecht) said he took a great interest in the new facts. 1. He thought that in inflammatory cataract during life it was directly seen that the lens was advanced and pressed against the pupillary parts of the iris. Here the (merely physical) adhesive apposition would suffice for impeding the free communication between the peripheric part of the posterior chamber and the anterior chamber. In the posterior there might be higher pressure, accounting for the dilatation found by Dr. Brailey, the atrophy of the ciliary processes, and pulling of the periphery of the iris in the direction of the ligamentum pectinatum, with inflammation and adhesion to the cornea near the canal of Schlemm. 2. The dilatation of the peripheric arteries of the iris seemed to be in relation to the visible dilatation of the anterior ciliary arteries. Injection might be tried even in extirpated eyes (as Schroeder van der Kolk was able to do). 3. The lens seemed swollen in every acute glaucoma. As to

the suggested increase of size of the lens with increasing years, even up to the extreme old age, it would be a good plan, not only to test it by measurements, but also to weigh the lens, as great accuracy could be thus attained.

The Cicatrix of Filtration Theory.

Mr. G. E. Walker, F.R.C.S. (Liverpool), gave his views of iridectomy, sclerotomy, and hyposcleral cyclotomy; viz., that tension was diminished by relieving the inflammatory infiltration of the ciliary body.

Hyposcleral Sclerotomy.

Mr. C. Higgins, F.R.C.S. (London), referred to Mr. G. E. Walker's *Essays in Ophthalmology*, in which hyposcleral cyclotomy was described, and its results in several cases given. The expectations raised by perusal of the essay in question were scarcely realized. Seven cases were reported; and the experience of these led the writer to believe that "hyposcleral cyclotomy," as a means of reducing ocular tension, was inferior to iridectomy, but superior to sclerotomy, trephining or seton.

Mr. Vose Solomon (Birmingham) gave several reasons which, he thought, explained the alleged prejudice among some general practitioners against the employment of iridectomy. Referring to the first introduction of that operation as a remedy for tension of the eyeball, he confessed to have been much pained at the time—and even now in the retrospect—by the hostility and discouragement, emanating from an influential centre, directed against all independent efforts to cure ocular tension by any other surgical procedure than an excision of the iris. He had seen tension that persisted after an iridectomy permanently relieved by a section made through the base of the coloboma and the ciliary structures. The same operation, attended by an escape of vitreous humor, he had known to permanently relieve other cases. From the dictum that, given tension, iridectomy must, therefore, be performed, he had always withheld his assent. The operation of intraocular myotomy, which he proposed some few years ago, divided, to the extent of two lines, all the structures depicted in Dr. Brailey's diagram; and cases of acute glaucoma so operated upon had suffered no relapse in the course of fourteen years The incision was made through the corneo-scleral tissue, removing the pillars of the iris and the ciliary muscle; the sclera was not cut in this operation, and the vitreous humor should not enter the wound.

Dr. Argyll Robertson (Edinburgh) expressed his dissent from the views of Mr. Priestley Smith, as to the causation of glaucoma. He also thought that the approximation of the anterior surface of the iris to the inner surface of the cornea could not be satisfactorily explained by a contraction of the fibres of the ligamentum pectinatum, which, in his opinion, could only draw the pupillary margin of the iris nearer to the ciliary processes, but could not alter the plane of the iris. He further expressed the opinion that the occurrence of a cystoid cicatrix after iridectomy, was of the greatest benefit in securing a permanent diminution of tension, by permitting transudation of fluid from the interior of the eye, and cited a case in which, on recurrence of glaucomatous tension after iridectomy, he had recourse (on the advice of Mr. Bowman) to sclerotomy, which was followed by a cystoid cicatrix, and a permanent reduction of tension. In his own operation of trephining the sclerotic, his object was to replace a disc of the firm, resisting sclerotic, by a loose, yielding, readily permeable tissue, which acted the part of a safety-valve to a boiler, saving the sensitive retina, etc., from the evil effects of pressure, and also allowing the transudation of fluid from the interior of the eye. He desired to mention that, in the case narrated in his original paper, in which, both eyes being affected with glaucoma, he performed a free iridectomy on the better eye, and trephined the sclerotic on the worse, the patient was now blind in the eye that was iridectomized, but retained fair vision in the other.

The President, in bringing the discussion to a close, remarked upon the immense advance achieved through the researches—anatomical, physiological and pathological—which the glaucoma problem had been the means of eliciting during the last twenty years. We now looked upon the aqueous chambers of the eye, not only as a space within which the relative position of certain optical structures and their needful movements were provided for, but also as an arrangement securing a nearly equable elastic support for all parts within the globe, under varying nervous and vascular conditions. The aqueous humor seemed not to be a stationary fluid, or quite a fixed quantity. It was being ever secreted, and ever in course of being removed, through the rim of the anterior chamber, from the receptacle which it occupied. It also, probably served for the more effectual nutrition of the neighboring non-vascular vitreous body and lens. By it, the intravascular and intraocular pressures were held in mutual harmony within certain limits, the limits of health. When this harmony was impaired by an arrest of the due escape of aqueous humour through Schlemm's canal, the intraocular tension rose, and the secondary evils of glaucoma followed. Most interesting questions had been propounded, and still awaited solution, as to how, under different circumstances, the balance of elasticity was lost; and especially how that adhesion of iris to cornea, and consequent mechanical closing up of the rim of the anterior chamber was brought about, which in many, though not all of the cases of established glaucoma, seemed to account for the high tension. It appeared to be a matter of the greatest interest, and might have the most direct bearing on practice, that we should, if possible, understand the *rationale* of the glaucomatous process. He entirely agreed with Professor Donders, that the most exact anatomical account of the natural structures, and of the morbid deviations, was our first requirement—the *sine qua non*. We still wanted also the detailed clinical histories of numerous cases, in connection with the indispensable, exact, and true examination of the tissues concerned, for there were many anomalies waiting for explanation; and this, to be satisfactory, must be a general and comprehensive one.

Editorial Department.

Periscope.

The Cause and Treatment of the Bad Odor Sometimes Associated with Excessive Sweating of the Feet.

George Thin, M.D., in an article on the above subject, published in the *British Medical Journal*, September 18, 1880, says—

Profuse sweating of the palms and soles is not uncommon, but, in order to produce the specific odor to which I refer, something more than mere profuse sweating is required. The excessive perspiration, when confined by stockings and boots, macerates the epidermis, and, if the person stand or walk much, the skin of the heels becomes tender. This tenderness is accompanied by redness, slight blistering, or more decided localized eczema. In damp, relaxing weather, perspiration is increased; and we have thus two causes of aggravation, each potent, but both together very powerful—moist warm weather and prolonged pressure by walking or standing.

It has been pointed out by Hebra that the evil smell is not in the sweat itself, but in the coverings of the feet; a fact which it is easy to verify.

The patient who has afforded me the opportunity of investigating the cause of the smell, is a young woman, aged twenty-two, who has suffered from evil-smelling feet, with soreness of the heels, for several years. Her hands are usually moist, or even wet, but are always odorless. The smell from the feet is not constant, disappearing in dry, bracing weather, and reappearing when the weather is moist and depressing.

The experiment I made was to subject the soles of the stockings and boots to the action of an antiseptic solution. The success was complete, the odor being entirely banished. The antiseptic precautions having been soon neglected, the smell returned, and I took the opportunity of investigating its cause more minutely.

The sole of the stocking, a few hours after it was put on, was found to be quite wet; and a stocking, if worn for a whole day, was so extremely offensive that, when held close to the nostrils, its overpowering fetor was comparable to that of putrid blood. The inside of the boot was equally wet and offensive; but at the very time that the stocking and boot smelt so strongly, the heel itself, exuding moisture profusely, had no disagreeble odor. The sole of the heel was reddened and tender, and macerated around the edge, like a washerwoman's palm.

The reaction of the moisture in the stocking and in the sole of the boot was alkaline, that of the moisture exuding from the skin of the sole of the heel faintly alkaline, while that of the perspiration of other parts of the body was acid.

The fluid from the sole of the heel was thus shown to be not pure sweat, the faintly alkaline reaction being doubtless due to the serous discharge accompanying the eczema set up by the local hyperidrosis.

The fluid in the sole of the stocking was found to be teeming with bacteria forms, the nature and development of which I have carefully investigated. These investigations have produced results of some scientific interest, which I have communicated to the Royal Society. The rapid development of bacteria in the fluid which exudes from the soles is doubtless favored by the alkaline reaction produced by the mixture of serous exudation with the sweat.

The treatment instituted in this case is as simple as it has been effective. The stockings are changed twice daily, and the stocking-feet are placed some hours in a jar containing a saturated solution of boracic acid. They are then dried, and are fit for wear again if it be desired. The boracic acid effectually destroys the smell. But to kill the bacteria in the stocking is not enough. The leather in the bottom of the boot is wet and sodden, and smells as vilely as the stocking. This difficulty is got over by the use of cork soles. I directed my patient to get half a dozen, which she finds sufficient. A pair must only be worn one day unchanged; at night they are placed in the boracic jar, and are put aside the next day to dry. If these directions be accurately carried out, the evil smell is perfectly destroyed.

The boracic acid solution is an excellent application to the painful skin in these cases. When the tender skin of the soles is washed with it, a sensation of coolness succeeds the feeling of heat and tension which are the usual accompaniments of the eczematous condition associated with the smell, and the skin becomes harder and loses its abnormal redness.

The bacteric fluid would seem to act as a direct irritant to the skin. My patient assures me that, if she wears stockings which have been dried without being disinfected, irritation is speedily felt; and that the cork soles, if worn a second day without having been purified, act in a similar way.

The Treatment of the Pain Resulting from Nerve Injury by Subcutaneous Division of the Nerve.

J. H. Pooley, M.D., of Columbus, Ohio, relates the following case, in the *Ohio Medical Recorder* for October, 1880:—

Mr. Goddard, an elderly gentleman, consulted me for a painful affection of the finger, resulting from the scar of a felon from which he had suffered many years before. The forefinger of the right hand is very much deformed at its extremity by an old contracted cicatrix, the skin is closely adherent to the bone and presents that peculiar shiny and congested appearance now generally recognized by surgeons as indicative of nervous injury. He says that for years he has never been able to get to sleep for an hour or two after retiring, from pain in this finger, together with a nervous, thrilling sensation, which it is impossible for him accurately to describe; he states that his ordinary method of wooing sleep and forgetting his annoyance is by attempting to solve some difficult mathematical problem

in his mind; and during the day, except when his attention is diverted by other things, it is a constant source of more or less uneasiness.

After explaining to him what I supposed to be the rationale of it, and telling him that I could not promise that it would cure him, I, at his request, divided the nerves of the finger by a subcutaneous incision. This was accomplished by passing a tenotome under the skin at the root of the finger on its inner side, and dividing all the tissues down to the bone, and repeating the manœuvre on the opposite side, thus completely girdling the finger subcutaneously, dividing all the tissues except the flexor and extensor tendons. The operation gave him complete and permanent relief. In Sir Benjamin Brodie's "Lectures on Surgery," that distinguished surgeon mentions the case of a young lady who had a train of most severe hysterical symptoms following the accidental prick of her finger, in which he divided the digital nerves very much in the same way as I have just described. The result was that the patient's sufferings were aggravated rather than relieved. I have seen a case in which symptoms which might very well be called hysterical were produced in a gentleman by stepping barefooted on an upturned carpet tack, but they were quite transient in duration. Symptoms of greater or less severity were quite common from nerve prick during the times when bleeding was in vogue. According to Ambrose Pare, Charles IX suffered severely for three months from an accident of this kind, and all the older surgeons allude to it.

On Vaccination.

The Committee on Hygiene of the Medical Society of the County of Kings lay down the following propositions as a result of their investigations into the causes of alleged futile and bad results following vaccination.

1st. Vaccinate with only pure virus, animal or humanized, every child, when possible, before five months of age.

2d. The value of vaccination is lessened by lapse of time, so that re-vaccination is necessary between the tenth and fifteenth year.

3. It is wisdom to vaccinate before an epidemic occurs, as has been repeatedly urged by ex Sanitary Supt. Dr. Segur, before the public is excited, and when virus can be readily obtained. As the danger of small-pox is great, children who might not be considered in proper condition for vaccination at other times should be vaccinated during the prevalence of variola.

4th. Children should not be vaccinated during an eruption of teeth, the prevalemce of an epidemic of diphtheria, in the hot weather, if it can be avoided, or where there is any skin eruption.

5th. The causes of "spurious vaccination in the Confederate army," as investigated by Prof. Joseph Jones, are interesting in this connection, viz:—

1st. Lowered vitality—scorbutic condition.

2d. From abnormal lymph, from persons previously vaccinated or having eruptive diseases.

3d. Scabs or lymph undergoing decomposition, long carried about the person.

4th. Mingling vaccine virus with that of true variola, as in persons having varioloid.

5th. Virus from persons having erysipelas, pyæmia, gangrene and suppurating wounds.

6th. Lymph-scabs, etc., from persons suffering from syphilis.

Use of Olive Oil in Large Doses for Softening and Causing the Easy Expulsion of Biliary Calculi.

Roderick Kennedy, M.D., of Kingston, Canada, writes as follows in the *Lancet*, September 18th, 1880:—

It is scarcely a matter of doubt that the means resorted to for solution and expulsion of biliary calculi have hitherto proved slow and uncertain in their operation. Systematic writers, as a rule, do not attach a great deal of weight to the value of the so-called solvents. Not a few incline to the view that remedies of this kind are practically all but inert. Others assert in plain terms that medicines having these powers do not exist. Chloroform alone, or with ether, in the hands of some, is said to have removed these bodies, but this mode does not seem to have come into general use, probably because it requires time, and the proof of success is inferential. A simple medicine, readily available in practice, and having the power of softening and expelling biliary calculi, it will be admitted has hitherto been a desideratum. Such a medicine I have during the past year used in a variety of cases, and, I am happy to say, always with complete success. In every instance in which the calculi were proved or presumed to have been the cause of periodic suffering, these bodies were promptly and painlessly expelled in larger or smaller numbers by the use of large doses of olive oil. In some instances lately, where the patients did not exhibit symptoms of such acute suffering as are more commonly witnessed, but where obstruction to proper flow of bile was evident, I had recourse to this remedy, and in these cases also have been rewarded with similar surprising and satisfactory results.

A brief notice of a few cases illustrating the effects of the means used may prove to be not without interest.

Robert C., of Adolphustown, an elderly farmer, had for some years been subject to hepatic disorder, attended with the occasional passing of gall stones. The intervals between the passing of the bodies had gradually become more brief, and lately the paroxysms, always characterized by intense suffering, had come on at intervals of about a week with great regularity. I found the patient anæmic, sallow, and very much exhausted. The usual remedies for the gradual solution of the stones had been tried, but radical relief not being obtained, mitigation of the intense suffering was what, previous to my being sent for, had been principally aimed at. I ordered six ounces of the oil to be taken at bedtime, to be followed in the morning by a full dose of castor oil. No motion of the bowels was obtained till next evening, after the administration of an enema. Twelve hours after taking the oil the patient began to complain of a good deal of nausea and faintness, and for several hours there was considerable restlessness, and constant ap-

prehension that the usual paroxysm was about to come on, but no acute pain. In the evening the enema was followed by several copious motions, each containing numbers of softened gall stones, amounting in all to not fewer than two hundred, varying as to size from a large hickory nut to a small pea, of a pale, yellowish-green color, semi-transparent, soft, easily broken up, and of a great variety of shapes. The patient had a good night's rest, and expressed himself in the morning as feeling very much better, and enjoyed a light breakfast. After the lapse of two days, the paroxysms threatening to return, I ordered the oil to be repeated two nights in succession. The expulsion of a quantity of slimy, bilious-looking-matter followed, but no more calculi. The calculi had evidently become dissolved. The patient was left with directions to repeat the use of the oil a few times, at intervals of two or three weeks, and after this as might be indicated by the recurrence of symptoms threatening the return of the paroxysms. I saw the patient five months after my first visit. While there were indications of organic disease of the liver, no more calculi had been passed, and the paroxysms had ceased to return.

Mrs. W. F., of Ernesttown, presented a case very similar to that of C. She had for some years suffered from fits of intense pain, generally coming on after a hearty meal. She was directed to take full doses of the oil for two consecutive days. She passed about two hundred calculi, varying in size from a grain of wheat to a filbert. The periodic attacks of pain ceased with the removal of the gall-stones.

Gabriel B., and Clinton F., both of this township, each presented a case of hepatic disease, characterized by obstruction to the flow of bile, accompanied by severe pain. The oil was administered with the effect of removing softened calculi of considerable size, but in smaller numbers than in the preceding cases, the general symptoms being relieved. A number of other cases might be referred to, in all of which the power of the oil to soften and facilitate the expulsion of biliary calculi was shown to be prompt and unequivocal.

The material point which may be deduced from these cases is that olive oil, administered in repeated *large* doses, seems to have an unquestionable power of so softening and partially dissolving biliary concretions as to render their expulsion comparatively easy.

Another fact I have noticed is, that although the administration of the oil at intervals of a few weeks or months does prevent the re-formation of the concretion for the time, yet the resort to the oil alone does not alter the causes or diathesis upon which the formation of these bodies depends.

Elixir Chloroformi Compositus.

Dr. W. F. McNutt, Professor of Principles and Practice of Medicine, University of California, says, in the *Western Lancet* for August:—

I have been in the habit for several years of prescribing Collis Browne's chlorodyne in certain cases of asthma, colic, diarrhœa, neuralgia, rheumatism, hysteria, etc. It has seldom failed to be of some benefit, and often acted like a charm; in fact, I found it a most excellent and reliable anodyne, anti-spasmodic and sedative.

On account of several objections to its use, I have, after a great deal of experimentation, adopted the following formula as a substitute for chlorodyne, viz.:—

℞.	Morph. mur.		gr. ss
	Chloral hyd.,		
	Chloroform,	āā	ʒ ss
	Tinct. cinnab. ind.,		
	Tinct. capsici,		
	Acid hydrocyan. dil.,	āā	♏xx
	Spts. menth. pip.,		♏x
	Syr. sassafras co.,	ad	ʒj.

Dose, one drachm.

This I have named elixir chloroformi compositus, and can heartily recommend it to those who have been in the habit of using chlorodyne. To those who have never used chlorodyne I may say that they will find elixir chloroformi compositus a most efficient remedy for many purposes and under many circumstances; for instance, in whooping cough, asthma, emphysema, cough of many phthisical patients, in many cases of hysteria, and especially in many cases of dysmenorrhœa, it certainly has no equal. Given as an anodyne, it seldom produces headache or disturbance of the digestion, as does morphine, or depresses the heart's action, as does hydrate of chloral. In diarrhœa accompanied with cramping pains and tormina, in teaspoonful doses repeated every two or three hours, it generally acts quickly and satisfactorily.

In many cases of diarrhœa in children a few drops of the elixir, together with a few drops of castor oil and vini ipecac., in syrup of acacia, make a most efficient remedy.

The objections to chlorodyne are—

1. It is very expensive in this country.
2. It is not a perfect mixture, as it separates.
3. It is too concentrated to be safe for general use.
4. And, principally, it is a patent medicine, the exact formula for which is unknown.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——"The Practical Utility of Vivisection" is discussed by Horatio R. Bigelow, M.D., of Washington, D. C., in a reprint from the *Maryland Medical Journal*, for October, 1880.

——The September number of the *Rocky Mountain Medical Review*, a new journal, the advent of which we announced some time ago, is before us. It is edited by A. Wellington Adams, M.D., assisted by James A. Hart M.D., and several associate editors, and is published monthly at Colorado Springs, Colorado. To judge from the contents and attractive appearance of the first number, this will be a first-class journal. Sub-

scription price $5.00 per annum, payable in advance; single copies 50 cents.

——"Hernia in Children," is the subject of a treatise by Edward Swasey, M.D., of the Hospital for the Ruptured and Crippled, New York, based on a study of five hundred cases and on personal observation, which comes to us in a reprint from the *American Journal of Obstetrics and Diseases of Women and Children*, for July, 1880.

——A Reprint from the *Kentucky Medical Herald* contains "Notes on the Management of Orthopedic Cases," read before the Kentucky State Medical Society, Lexington, May 20th, 1880, by Virgil P. Gibney, M.D., Assistant Surgeon to the Hospital for the Ruptured and Crippled, New York. The same author also sends us a reprint from the Chicago *Medical Journal and Examiner*, for June, 1880, containg a report of fifteen additional cases of "Perinephritis in Children," completing a total of twenty-eight, with remarks on Diagnosis and Prognosis.

BOOK NOTICES.

A Treatise on the Diseases of the Eye. By J. Soelberg Wells, F.R.C.S., Doctor of Medicine of the University of Edinburgh; Professor of Ophthalmology in King's College; Ophthalmic Surgeon to King's College Hospital; and Surgeon to the Royal London Ophthalmic Hospital, Moorfields. Third American from the third English edition, with copious additions, by Charles Stedman Bull, A.M., M.D., Surgeon and Pathologist to the New York Eye and Ear Infirmary; Lecturer on Ophthalmology in the Bellevue Hospital Medical College. Illustrated with two hundred and fifty-four engravings on wood, and six colored plates, together with selections from the test-types of Prof. E. Jæger and Prof. H. Snellen. Philadelphia, Henry C. Lea's Son & Co. 1880. 8vo., pp. 895. Price, cloth $5; leather $6; half Russia, raised bands, $6.50.

It is with great pleasure that we welcome a new edition of this standard work on ophthalmology, the last edition of which has now been out of print for some time. The death of the author having prevented his revising the work himself, this task has been undertaken by the American editor, who has taken great pains to introduce in it all the advances which observation and experience have acquired for the theory and practice of ophthalmology since the appearance of the last revision in 1873. Numerous and extensive additions have been made, especially in matters relating to pathology and treatment, and a number of new illustrations have been added, rendering the present edition almost encyclopedian in its character. The chapter on *the anomalies of refraction and accommodation of the eye*, a subject which, of late, has attracted a great deal of attention, is very complete; and this is a subject of the greatest importance, not only to the specialist, but also to the general practitioner, on account of the many apparently obscure nervous diseases which are thus produced, and consequently may be relieved by wearing proper glasses. General practitioners should also have, at least, a sufficient knowledge of ophthalmology to enable them to treat rationally the most common diseases of the eye, or to determine when their patient ought to be sent to a specialist; and a careful study of a work like this would enable them to save many an eye which otherwise would be lost for the want of proper treatment. The work is gotten up in good style, and has very much the same appearance as the last edition. It is, however, not entirely free from typographical errors.

Transactions of the State Medical Society of Kansas at its Fourteenth Annual Session, held in Leavenworth, Kansas, May 11th, 12th, and 13th, 1880. pp. 107.

The President, Dr. C. C. Turley, of Wichita, urged, in his address, the necessity of strictly enforcing the law regulating the practice of medicine, and suggested that steps be taken to create a law regulating the sale of drugs. Among the papers read were: "Neuromatous Tumor, with Excision of a Section of the Great Sciatic Nerve," by Dr. J. A. Coons, of Spring Hill; an "Anomalous Bigeminal Pregnancy," by Dr. Geo. H. Randell, of Easton; "Antiseptic Surgery," by Dr. T. S. Floyd, of Sedgwick; "The Recent Advances of Medicine and Surgery of the Eye," by Dr. B. E. Freyer, U. S. A., of Fort Leavenworth; "Treatment of Syphilis, by Hypodermic Sublimate Injections, by Dr. F. Sieber, of Ellsworth; and several other papers and reports. The report of the Examining Board shows energy and determination to rid the State of quacks. A complete list of the regular graduates practicing within the State, and those who have successfully passed the board, as well as those who were rejected, is given.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

WHO'S TO BLAME FOR THE BOGUS DIPLOMA BUSINESS?

The medical societies, the medical colleges and the medical journals of Philadelphia have this summer, severally and collectively, had to bear a certain measure of criticism, not to say abuse, from other societies, colleges and journals, because the final uprooting and overthrow of John Buchanan's bogus diploma shop were effected by the agency of a daily paper, and not through the instrumentality of any medical body or organ. We have been styled timid, dull, unenergetic, too dignified, too slothful; what not?

It is the part of an honest man to acknowledge his faults; and as an honest body, the Philadelphia profession must acknowledge that it is to blame in this matter. Let the truth be told. There was a hesitation in the profession, on all sides, about attacking Buchanan's concerns. The matter was suggested to the county society; but it had had a recent experience, in assisting in a lawsuit which had proved a costly and not at all encouraging one. Nearly ten years ago the then editor of this journal collected ample evidence of the illegal action of Buchanan, and personally submitted it to the Dean of one of our two well-known medical schools, asking for moral support and financial backing in pushing the diploma vendor to the wall. He got neither; and disgusted and discouraged at such lukewarmness, he renounced the hope of breaking up the iniquitous concern. There are wealthy physicians in Philadelphia, but none of them came forward to supply the sinews of war when needed.

This is all true, and pity 'tis 'tis true. But there were difficulties to contend with far greater then, than later. Some years ago Buchanan was a power in the pot-house politics of this city; he was befriended by men in place, to whom he could make himself useful, and who would and did defend him by indirect but efficient measures. He had not sunk so low then as later, and he apparently had more money. The fight would have been a much more determined one. Again, if this suit had been brought by any professional man or body, the defendant would have laid it all to professional jealousy, and the public and the jury would have been fools enough to believe him.

It may be said that these are lame excuses. So is any excuse for shirking a duty. And we may be allowed to remind our critical brethren that if they look sharply around near home they will probably find some duties of a similar character that they are overlooking, through their eagerness to point out the shortcoming of the profession in Philadelphia. There are schools in New York, in Cincinnati, in Boston, in Louisville (if we may credit what we read in the medical journals of those cities), which, if not so unblushing, are every whit as unscrupulous and as injurious to the public as this shop of Buchanan's; more so, perhaps, because some of them sail under honest colors, while Buchanan deliberately swung out the black flag.

Again, why are so many ready to buy diplomas when they have little or no medical knowledge? Because, the regular profession in most States is too slothful or too timorous to have acts passed by the legislatures which will

nip the budding hopes of quackery. After all, it is not the fault of the Philadelphia profession, but of the profession of all this land, that there has been and is this demand for venal sheepskins. As we are honest, let other journals be honest, and assume the full share of the blame which attaches to them and the profession of their own vicinity.

For a time, Buchanan was driven from this city and State, and established his "University" in a back room, first at Haddonfield and then at Jersey City, New Jersey. Just as long as the profession allows the possession of a diploma to be sufficient evidence of medical qualification, there will be institutions ready to furnish them dirt cheap and of corresponding value.

The remedy for this state of things is to have a Chapter of Medical Colleges, in all of which honest work is demanded of students, and from which diplomas will be received as evidence; while all physicians hailing from foreign or schools other than those included in the Chapter shall be required to pass a fair examination in English before they are granted a license to practice. This is the rule in most European countries, and even the South American Republics and Mexico take this much care of their inhabitants. It is high time that we scrambled up to the same level of civilization. It is obvious that this once reached, the bogus diploma lay would lose all the attractions of a profitable business.

Notes and Comments.

Therapeutical Notes.

DISGUISING THE TASTE OF THE BROMIDES.

The *Canada Medical Journal* says that the bitter taste of the bromides is easily overcome by giving three drachms of simple syrup with each drachm of the bromide. The three drachms of syrup, if properly made, should contain about 150 grains of sugar. This completely alters the taste, giving it an agreeable nutty flavor, not unlike cocoanut-milk; if largely diluted, children take it with avidity. It is a boon to epileptics and others, who have to persevere in large doses of the bromide.

EXCESSIVE FOOT SWEATING.

A correspondent writes to the *British Medical Journal* a plan for curing this nauseous malady: "A plan I always adopt, and have always found successful in a few days (say from seven to fourteen). The feet are washed well over-night, and then enveloped in about a couple of folds of linen dipped in equal parts of hot water and the following:—

℞.	Zinci sulph.,		ʒ j
	Glyc. acid. carbol.,		f. ʒ ij
	Aquam,	ad	ʒ viij. M.

The linen is tied on by a couple of pieces of tape, and the patient goes to bed, keeping the feet out at the bottom. This is done night after night, with improvement at once, and the cure in the time at first stated. I have known one case in which the disease recurred in two or three months, but quickly yielded to a repetition of the treatment."

REMEDIES FOR TÆNIA.

Dr. Berenger-Féraud (*Rev. de Therapeutique*), as the result of trials on a large scale at the St. Mandrier Hospital of the different remedies for tænia, comes to the conclusion that the most powerful and certain of these is *pelletiérine*, the active principle of pomegranate bark.

BENZOATE OF SODA IN PERTUSSIS.

Dr. Tordeus, of the Hospice des Enfants Assistés, Brussels, states that he has found the benzoate of soda very useful in several cases of whooping cough, diminishing the frequency and violence of the paroxysms, and, by its action on the pulmonary mucous membrane preventing those pulmonary complications which so frequently supervene and constitute the danger of the disease. He uses the formula employed by Setzenich in diphtheria, viz., benzoate five parts, peppermint-water and distilled water of each forty parts, and syrup of orange-peel ten parts; a teaspoonful every hour.

DANGER OF COMBINING ANODYNES.

A writer in the *Lancet* calls attention to the danger of administering chloral, bromide of potassium and opium, or of giving them one after the other. Serious collapse or fatal coma may follow quite moderate doses. He gives this case: The patient, a young man, had been delirious for some time. Chloral hydrate had been given without any beneficial effect. A second opinion was called in, and it was decided to give a subcutaneous injection of morphia of one-fourth or one-sixth of a grain. The patient soon became quiet, livid, and died in two hours. The doses were not above those usually given, yet death followed.

Female Delegates to the International Medical Congress.

The bigotry of the directors of the next International Medical Congress, in excluding female delegates, received a well merited rebuke in a late number of *Le Progres Médical*. After referring to the fact that sex has been no reason for exclusion from other Congresses, the editor asks:—

"Do they fear that the reputed loquacity of these ladies would cause the Congress to waste too much time? Does past experience confirm this dread, and sanction these precautions? Alas! if they wanted to exclude babblers, those inexhaustible debaters who only speak to say nothing, they must have recourse to more radical measures; and perchance, the rigors of a new rule would frequently fall upon the bearded orators.

"In France—the salic land—we are less timid; the Société d'Anthropologie cordially admits women among its members, and does not bind them to silence. The English Committee of the International Congress of London, which Her Majesty the Queen of England and Empress of India has deigned to take under her high patronage, should have been able, without derogation, to show more courtesy toward the sex to which their sovereign belongs."

Conjunctivitis from Chloral.

Dr. J. H. Emerson, at a recent meeting of the New York Clinical Society, mentioned a case of ophthalmia produced by the use of chloral hydrate. The patient, a young man, was subject to attacks of asthma, and in two severe attacks, chloral, in ten- or fifteen-grain doses, had afforded great relief. This led him, during a recent attack, to employ it each night for some time. Shortly after he began its use the conjunctiva of the globe and lids became injected, and photophobia existed, with profuse lachrymation. The latter, as it occurred in the left eye, did not correspond with the degree of photophobia. The affection of the eyes required him to keep his bed. Iodide of potassium, which he had been taking, had been discontinued for some time, and the resulting acne and throat irritation had disappeared. There seemed to be no cause therefore, other than the use of chloral, for the ophthalmic trouble. The treatment first adopted was the application of camphor-water and borax, then of sulphate of zinc and rose water, but no improvement resulted. The chloral was then discontinued, and immediate improvement took place.

The Epizootic Disease.

Beginning a month ago, in the extreme north of New England, the so-called "epizootic disease" has extended southward, until now the horses on the Atlantic coast as far down as Washington are largely suffering from it. About forty per cent. of those in this city are at this date more or less sick. The type of disease is not severe, but it is well-known that the sequelæ are often obstinate and troublesome.

A full description of the malady is given in Tellor's *Diseases of Live Stock*. He states that the immediate cause is wholly unknown, but that the treatment is clear and efficient. The medication he recommends, from English and American authorities, is tolerably active, and careful nursing is essential. Belladonna (or atropia), he states, gives immediate relief to the spasmodic cough and noisy, difficult respiration. It were well for physicians to post themselves on this epidemic, as well for their own as for their neighbors' animals.

The Etiology of Diabetes Mellitus.

There is increasing probability that diabetes mellitus is nothing more than one of the symptoms of one or more diseases of organs quite remote from the kidneys. One evidence of this is the variety of remedies which at times act markedly beneficially. Glycerine, first recommended by Schultzen, has recently succeeded admirably in the hands of Von Holst; while, in the September *Practitioner*, Dr. J. W. Hunt, of London, has a case rapidly restored by the administration of ergot. Dieting in some instances is sufficient of itself; in others, it seems to have no material effect. Dr. M. Charteris reports "striking success," in the Glasgow Royal Infirmary, from pilocarpin, gr. $\frac{1}{20}$, thrice daily (*Lancet*, September 25th).

Cresolene in Whooping Cough.

The petroleum derivative cresolene is recommended in pertussis by Dr. J. H. Egan of Tennessee. The cresolene is vaporized and not atomized. The vaporizer consists of a metal cup, two inches in diameter and one inch deep, and diaphragm, supported by standards six inches in height. An ordinary toy kerosene lamp will furnish the necessary heat for twelve hours. Atomizing and spraying impregnate the atmosphere for a limited time, as the particles weighted with water instantly gravitate to the ground. With a vaporizer the vapor is diffused to every part of the room. Should the smell of the cresolene be offensive, a

few drops of perfume will remedy the evil. It is best to use the apparatus at night, closing the windows and doors so that the vapor may be confined.

Salt as a Prophylactic in Diphtheria.

In a paper read at the Medical Society of Victoria, and published in the *Australian Medical Journal* for June, 1880, "On the Free Use of Salt as a Prophylactic against Diphtheria," Dr. Day stated that, having for many years past looked upon diphtheria in its early stage as a purely local affection, characterized by a marked tendency to take on putrefactive decomposition, he has trusted most to the free and constant application of antiseptics; and when their employment has been adopted from the first, and has been combined with judicious alimentation, he has seldom seen blood poisoning ensue. In consequence of the great power which salt possesses in preventing the putrefactive decomposition of meat and other organic matter, Dr. Day has often prescribed for diphtheritic patients living far away from medical aid the frequent use of a gargle composed of a tablespoonful or more of salt, dissolved in a tumbler of water; giving children who cannot gargle a teaspoonful or two to drink occasionally. During the prevalence of diphtheria he recommends its use instead of sugar in the food of children, adults using the gargle as a prophylactic, three or four times a day.

The Advantages of an Exclusively Vegetable Diet for Children.

Dr. T. S. Clouston is Lecturer on Mental Diseases in the University of Edinburgh, and a recognized authority in this branch. He says, in a recent article—

My experience is that children who have the most neurotic temperaments and diatheses, and who show the greatest tendencies to instability of brain, are, as a rule, flesh eaters, having a craving for animal food too often and in too great quantities. I have found, also, a large proportion of the adolescent insane had been flesh eaters, consuming and having a craving for much animal food. My experience, too, is that it is in such boys that the habit of masturbation is most apt to be acquired, and, when acquired, seems to produce such a fascination and a craving that it ruins the bodily and mental powers. I have seen a change of diet to milk, fish and farinaceous food produce a marked improvement in regard to the nervous irritability of such children. And in such children I most thoroughly agree with Dr. Keith, who in Edinburgh, for many years, has preached an anti-flesh crusade in the bringing up of all children up to eight or ten years of age.

Operations for Umbilical Hernia.

In a communication to the Paris Société de Médecine, M. Polaillon related two cases of strangulated umbilical hernia, occurring in women, forty-one and forty-four years of age, both of whom recovered promptly after operation. He observed that these facts, taken with others which have been published, are of interest, as showing that umbilical hernia, when small or of medium size, may be operated upon with pretty much the same chances of success as in other forms of hernia. The excessive mortality which had attended the operation, and which led many surgeons to proscribe it altogether, was observed before antiseptic treatment was introduced, and was due to suppurative peritonitis being so frequently set up. Under the antiseptic method immediate union usually takes place, and this danger is rendered very slight.

Milk Diet in Heart Disease.

The *Medical Press and Circular*, September 15th, 1880, informs us that at the recent meeting of the French Association for the Advancement of Science, M. Potain read a paper on this subject. Milk diet is particularly efficacious in secondary cardiac affections, as hypertrophy or simple dilatation of a gastric or renal origin. The diet modifies the condition of the kidney and the stomach, because it gives these organs almost complete rest; therefore, to be thoroughly efficacious, it should be absolute and more or less prolonged. It may be usefully employed in cases of simple reflex palpitation, of gastric origin. It may also be advantageously used for its diuretic action in dropsy, especially, and perhaps exclusively, when the dropsy is of renal origin.

Easy Test for Arsenic in Fabrics.

The following plan is recommended by Dr. Henry Barnes, in the *Practitioner*, as an easy plan to detect arsenic in paper hangings or any other suspected fabric:—

Immerse the suspected paper in strong ammonia, on a white plate or saucer; if the ammonia becomes blue, the presence of a salt of copper is proved; then drop a crystal of nitrate of silver into the blue liquid, and if any arsenic be present, the crystal will become coated with yellow

arseniate of silver, which will disappear on stirring.

This test is not so well-known as it should be. It is mentioned in some of the text-books, but we are not aware to whom the credit of its first introduction is due.

Diagnosis of Intoxication.

Dr. Shorthouse, in the *British Medical Journal*, August 21, says that according to his observation intoxication from wine or malt liquor is likely to cause its subject to fall on his side, whisky brings him down on his face, and cider or perry invariably lays him on his back. He supposes that the different drinks act on various organs of the cerebro-spinal system. A contemporary suggests that according to this theory a carefully adjusted mixture of beverages might be devised which should have the effect of exactly balancing the imbiber.

The Action of Erythrophleine.

MM. Sée and Bochefontaine are using erythrophleine, the active principle of the Mancona bark, in the treatment of different cardiac and respiratory affections. The plant from which it is derived, the Erythrophleum guineense, is employed in some parts of Africa as an arrow-poison. MM. Sée and Bochefontaine find that erythrophleine increases the vascular tension, and first slows the pulse and respiration. Then the respiratory movements are quickened, and when death takes place they persist long after the cessation of the cardiac contractions.

The Turkish Bath in Hay Asthma.

A sufferer from hay asthma writes to the daily press of this city, that by taking a Turkish bath daily, from the time the first symptoms appeared, he has, for three summers, succeeded in almost wholly escaping this most annoying complaint. He, moreover, does not have a relapse when cold weather sets in, and so far from finding the baths debilitating, they prove decidedly tonic.

Correspondence.

Fracture of the Patella.

Ed. Med. and Surg. Reporter:—

In Vol. xliii, No. 13, Med. and Surg. Rep., I notice a report of "Three cases of fracture of patella, treated on single inclined plane, with sand bag and extending weights," by J. S. Wight, M.D., Professor and Surgeon at the Long Island College Hospital, which leads me to publish a plan of treatment for the fracture above mentioned, used by me as early as 1872.

In July, 1872, Josiah D., aged about seventy, fractured the left patella near the middle, by stepping from a car while the train was in motion. I applied the spiral bandage as high as the tubercle of the tibia, then placed overlapping strips of adhesive plaster above and below the fragments—thus drawing them neatly together—and finished the spiral to the groin. After this, the single inclined plane was used. The patient never rested an hour while this rigging was in position, and finally became so clamorous to have it removed, that I set my wits to work to invent or discover an easier dressing. The result was that, after removing the bandage, I applied an adhesive strip to each side of the limb, from the middle of the thigh to the ankle; fastened the ends together beneath the foot; and attached a cord and weights—which passed over a pulley at the foot of the bed.

I then reapplied the spiral bandage (without disturbing the overlapping, transverse, strips of adhesive plaster, above and below the fragments) from the foot to the groin. The foot of the bed was elevated, to cause counter-extension. In other words, the treatment was precisely like that for fractured thigh, except that the transverse strips of plaster were used above and below the patella, and the sand bags, for the sides of the limb, were omitted. The pulley was elevated sufficiently above the bed to swing the limb clear. After this dressing had been completed, the patient was perfectly comfortable; and at the end of six weeks I removed the strips and bandages—complete union having taken place. The old man was shortly able to use his limb as well as ever. C. H. Shivers, M.D.

Haddonfield, September 26th, 1880.

The Cyanide of Mercury Test for Sugar in Urine.

Ed. Med. and Surg. Reporter:—

I noticed some weeks ago, in your journal, a query in regard to the cyanide of mercury test for sugar in urine. As it has not been answered, the following may be of use to your querist:—

Pure dry cyanide of mercury,	10 grm.
Solution sodic hydrate, sp. gr. 1.145,	100 c.c.
Distilled water,	q. s. ad 1 liter.

The cyanide should be dissolved in a portion of the water and mixed with the alkaline solution, then bring to the proper measure by the addition of water.

In using take say 100 c.c. and bring to the boiling point. Run the urine in from a burette, until a drop of the mixture placed in contact with a drop of solution of ammonic sulphide on a porcelain surface no longer develops a dark color. 100 c.c. of the solution will be completely reduced by 100 mg. of glucose.

Dr. Knapp, whose original paper upon this subject was published in the *Bulletin General de Therapeut.* October, 1871, claims that this method is better than Fehling's, because the fluid is absolutely permanent and the application is easier and quicker. The latter is not, in my opinion, the case, as the determination of the end reaction is exceedingly troublesome.

September 20th, 1880. Druggist.

News and Miscellany.

The International Laryngological Congress.

This Congress assembled at Milan last month. About fifty members were present. The most interesting discussions resulted from papers read on Tuberculosis as appearing in the Throat, by Messrs. Schmidt, Schnitzler, Lennox Browne, Ariza, and Zawerthal. The German professors mentioned several cases of cure of laryngeal phthisis, but their *confréres* from other countries did not appear to have been equally fortunate.

Other communications on syphilitic affections of the throat were read, notably one by Dr. Gougenheim of Paris, which elicited a lively discussion.

A most interesting case was exhibited by Professor Caselli, of complete removal, twelve months previously, of the larynx, pharynx, base of the tongue, soft palate, and tonsils, for an infiltrating lymphoid growth interfering with respiration and deglutition. The patient appeared in excellent health, swallowed easily both solids and fluids, and spoke distinctly by means of an ingenious apparatus acting after the manner of a clarionet.

The members of the congress were fortunate enough to be invited to be present at the cremation of two bodies in the public crematorium; the bodies were consumed in separate furnaces, and by rival processes. The first body was operated on in the furnace originally erected, which consists simply of a chamber containing a fire, fed by wood, which is heaped around the corpse laid on an iron grill; smoke issues freely from the chimney, and there exists a strong suspicion of an odor. The second cremation was effected entirely by gas, produced and driven into the furnace by the destructive distillation of wood; and, by an ingenious arrangement, three distinct processes of combustion take place, and neither smoke nor smell issues from the chimney. Those present were all strongly in favor of the second process, and were unanimous in considering that there was nothing repulsive in the arrangements. As this was in a measure a scientific investigation, those present were permitted to watch the disintegration of the bodies through windows in the walls of the furnaces. It may be interesting to state that the Cremation Society is firmly established in Milan, and that nearly sixty voluntary cremations have taken place during the past year.

The municipal authorities gave several *soirées* in their magnificent hall in the Palazzo Marino, and the members of the congress enjoyed the hospitality of their president, Dr. Labus. The next session will take place in Paris, in 1882.

Against Vivisection.

The last petition to Parliament, for the absolute abolition of vivisection, was signed by "one hundred representative men," among them Cardinal Manning, Prince Lucien Bonaparte, Alfred Tennyson, Robert Browning, James Anthony Froude, John Ruskin, the head masters of Rugby, Harrow and seven other large schools, twenty-one physicians and surgeons, and thirty-seven peers, bishops and members of Parliament. The memorialists take the ground that vivisection, even with anæsthetics, should by law no longer be allowed, and they quote the opinions of Sir William Fergusson, Sir Charles Bell and Dr. Syme, that "it has been of no use at all, and has led to error as often as truth."

They add, the utility, if proved, would not, in this case, excuse the immorality of the practice.

Practice Among the Chinese.

An English practitioner writes from Formosa:—

"The Chinese make, on the whole, very good patients. Occasionally some of them try our patience not a little. One gets a four days' supply of medicine away with him, the recipe bearing on it, 'a spoonful three times daily after each meal.' He comes back next morning for more, thinking to flatter you by stating that he drank the former quantity at one dose. Another has his arm carefully put up in splints, and on his next visit he brings his dressings in a separate parcel. They are great believers in internal administration, and although he have only a cut finger, it is difficult for a Chinaman to see why he should not get some medicine to 'eat.' They have peculiar palates, many of them, and can drink castor oil *ad nauseam*, a stage which is not so easily reached in their case as it is in ours."

The Canada Medical Association.

The following officers were elected at the late meeting of the Association: President, Dr. Caniff, Toronto; General Secretary, Dr. A. H. David, Montreal; Treasurer, Dr. E. Robillard, Montreal; Vice President for Ontario, Dr. J. A. Mullin; Secretary for Ontario, Dr. Adam Wright; Vice President, Quebec, Dr. G. E. Fenwick; Secretary, Quebec, Dr. G. A. Belleau; Vice President, Nova Scotia, Dr. McNeil Parker; Secretary, Nova Scotia, Dr. Lawson; Vice President, New Brunswick, Dr. J. Christie; Secretary, New Brunswick, Dr. P. Inches.

Halifax to be the next place of meeting, and the meeting to be held on the first Wednesday of August, 1881.

A Negro Gradually Turning White.

The Centreville *Observer* observes:—

"A negro man on Kent Island, by name Dan Webster, has been voting the Democratic ticket ever since his franchisement; and strange to say, from that cause or some other, he is gradually growing white. A considerable part of his face is now whiter than the whitest face of one of our own race."

This is probably a case of vitiligo, an affection of the skin common among the natives of India, where it is not uncommon to see an originally dark person covered all over with milky white spots, which gradually spread, until in some instances the entire body becomes as white as snow. The structure of the skin is not altered in any way, and the margins of the spots are sharply defined.

The Population of the World.

Dr. Behm and Professor Wagner, German geographers of standing, who have devoted much attention to the statistics of population, have just issued a new edition of their calculations. They arrive, after great labor, at results which we quote, because they modify materially the estimate popularly current in Great Britain:—

Europe	315,929,000
Asia	838,704,000
Africa	205,679,000
America	94,495,500
Australia and Polynesia	4,031,000
Polar regions	82,000
The world	1,455,923,500

The calculation for Europe, which must be substantially accurate, is much larger than the usual one; but even then the immense bulk of humanity, ten in fourteen of mankind, dwells in Asia and Africa.

The Medical Schoolmaster Abroad.

We are informed that a druggist in this city received from a physician the following prescription. There is evident need of a higher standard "somewhere:—"

Oil of Sweet alum	1 oz
Spirits Eithur nit	1 oz
Oil tirpentine	½ oz
Balsum Copubia	½ oz
spirits Camphor	½ dram
flavorite Whith cinemon	
3 times ½ hour before Meales	

Malaria in New England.

The increase of malarial disease, especially intermittent fever, in New England, is exciting considerable attention. The State Board of Health of Massachusetts, with its accustomed zeal and energy, has taken hold of the subject, and has already collected a mass of facts which is astounding, and confirms to the fullest extent the rumors heretofore prevalent.

The form of ague near Providence, R. I., is said almost to equal the worst forms in the southern States.

The Norristown Insane Asylum

When this institution was opened, a few months ago, it was feared that there would be a paucity of patients. It would seem that this apprehension was not well founded, since the committee appointed to prepare a statement to be submitted to the Board of Public Charities reports that an additional building will soon be needed, to accommodate the rapidly-growing number of applicants for admission.

American Public Health Association.

The next meeting of the Association takes place in New Orleans, December 7th. All who desire to attend should write at once to Dr. Edward Fenner, P. O. Box 479, New Orleans, the chairman of the Committee on Transportation, who will give information as to reduced rates, etc.

Items.

—One or two cases of yellow fever are reported from Key West.

—The cholera has been severe in some parts of Central Russia; seven hundred cases occurred in one government in August.

—Prof. Delpech, of Paris, distinguished for his works on hygiene, recently died suddenly, from heart disease, in his sixty-second year.

—The New York Medical Law imposes a fine of not less than fifty dollars nor more than five hundred, on every physician in that State who does not register his name, address, place of birth, and school of graduation. Nevertheless, we are informed many have not yet complied with the law.

—Diphtheria is very severe among the children of Johnstown. The *Tribune* of that place says: "The record for six weeks past shows a greater number of deaths from this disease, in proportion to population, than there were in Memphis during the worst period of yellow fever two years ago.

QUERIES AND REPLIES.

C. G., of New York, writes: Will you, or some of the readers of the REPORTER, please tell me if singing ever causes any trouble with the stomach? If so, of what nature, etc.

Ans.—We have never heard that it does, but perhaps some of our readers may know something more definite about it, and if so, we shall be glad to hear from them.

MARRIAGES.

GRANDIN—TODD.—On Wednesday, October 13th, 1880, at the residence of the bride's parents, by Rev. Dr. Roe, John F. Grandin, M.D., of Clinton, N. J., and Fannie Todd, of Lebanon, N. J.

McMILLAN—WOOD.—In Barnard, Vt., September 15th, by Rev. Moses Kidder, Andrew L. McMillan, M.D., and Clara A. Wood, both of Barnard.

SMITH—MERRILL.—At the Madison Avenue Presbyterian Church, on Monday, October 4, by the Rev. William Lloyd, Dr. O. H. Smith, of Brooklyn, and Mrs. H. S. Merrill, of New York.

SMITHSON—SMITHSON.—On September 7th, by Rev. T. M. Crawford, F. P. Smithson, M.D., and Fanny, daughter of James Smithson, Esq., all of Harford County, Md.

TYNDALE—WEST.—At Manitou, Col., September 2d, 1880, the Rev. W. D. Westervelt officiating, Julius H. Tyndale, M.D., of Manitou, and Mary L. West, daughter of the late Joseph West, of New York City. No cards.

WILEY—TITLOW.—At Norristown, Pa., September 9th, by Rev. Robert Adair, S. N. Wiley, M.D., and Mary E. Titlow, both of Norristown.

DEATHS.

FETHERSLY.—On August 15th, Wilkie Henry, son of Dr. A. P. and Susan E. Fethersly, of malignant scarlatina, aged one year and nine months.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1235] PHILADELPHIA, OCTOBER 30, 1880. [Vol. XLIII.—No. 18.

Original Department.

Communications.

ON CHOLOTOMY.

BY DR. E. E. MONTGOMERY.

Read before the Northern Medical Society, of Philadelphia.

Louisa P., aged thirty-five, domestic, of German descent, married, mother of five children, was admitted to the Philadelphia Hospital in April of the present year, suffering from cancer of the uterus and rectum, causing stricture of the latter viscus. The trouble began eighteen months ago, as an uneasiness about the rectum, difficulty in defecation, attended by straining and pain. The discharges were slight, liquid, of a muco-purulent and occasionally bloody character. This condition continued, better or worse at intervals, until five months ago, when it became permanent. She was treated for several months at the St. Mary's Hospital, with but little relief. She has lost flesh, becoming greatly emaciated; presents a sallow, cachectic appearance; complains of a want of appetite, nausea, frequent stools, largely of a muco-purulent and sanguineous character, attended by great straining and severe pain.

Until this illness she had enjoyed good health. She denies any syphilitic taint. Her habits have been none the best, being intemperate, and an inveterate user of snuff. Her father and mother are both dead; the latter died from "rectal obstructions," most probably cancer.

Menstruation has ceased.

Upon examination per vaginam, the uterus was found retroverted, hard, dense, fastened firmly in place; the rectum and posterior wall were also dense and resistant. The rectum was blocked, an inch from the anus, by a firm, annular stricture, that would not admit the point of the little finger.

April 14th the patient was etherized, and rectotomy performed, by passing upon the finger a probe-pointed bistoury, and cutting through the stricture toward the sacrum.

The rectal walls were found contracted and dense, so far as the finger would reach. The following day diarrhœa set in so severely as to endanger the life of the patient, but was controlled by bismuth and chalk mixture. Bougies were subsequently used, but were attended with such pain as to oblige them to be discontinued.

Our patient progressed from *bad* to worse; stools were thin, muco-purulent, attended with great straining and agonizing pain. Her skin was of a dirty brown color, and emitted an offensive odor. She was very weak; had lost her appetite, and suffered from nausea and frequent vomiting. In this condition I proposed to do colotomy, with a slight hope that it might allay her suffering and prolong her life.

April 28th, 9 A.M., the patient was again etherized and brought before the class, this time for the operation of colotomy. Her condition, however, was so feeble as to lead us to be very doubtful as to the efficacy of any operative interference. In the operation I was assisted by my colleagues, Drs. Parrish, Musser, and Stryker. The patient was placed upon the right side, with a good-sized pillow under the abdomen. As a guide, a stain was made with iodine at a point one-half inch posterior to the middle of a line drawn from the anterior to the posterior superior spine of the ilium. Beginning at the erector spinæ

mass, an incision, midway between the lower rib and crest of the ilium, was made obliquely forward four inches, through the skin, superficial fascia and lumbar aponeurosis, to the quadratus lumborum muscle, tearing through the lumbar fascia covering this muscle anteriorly; the gut protruded into the wound. It was transfixed longitudinally by two sutures, three-fourths of an inch apart, drawn out and an opening made between them. The gut was then attached to the skin by six wire sutures. The after dressing was simply some oakum saturated with carbolized oil. The patient stood the operation badly, and it was only by the continuous subcutaneous injection of whisky, by Dr. Parrish, that she survived. As soon as the patient could swallow, two ounces of whisky and twenty drops of digitalis were given, in carbonic acid water, and half an ounce of whisky and five drops of digitalis, directed to be continued every three hours.

1 P.M., temperature 100, pulse 120.

6 P.M., temperature 100⅘ pulse 100; is now able to take and retain milk in addition to whisky.

29th. Had a very good night; temperature 98, pulse 104; digitalis continued:

℞. Quiniæ sulph., gr.j
Tr. nuc. vom., gtt.v.

given every three hours. Wound was but slightly swollen, mucous membrane slightly everted, no fecal movement.

30th. Condition good, looks better than she has done for a week.

May 1st. Had a slimy mucous evacuation from the rectum.

May 2d. The first evacuation through the wound occurred this afternoon. The patient was not aware it had taken place. The superficial sutures were removed the following day. From this date the patient continued to gain, until at the end of the month she was able to attend to herself, and could go about the house at will.

October 8th. I found the patient this afternoon looking better than previous to the operation six months ago. She has a marked tendency to diarrhœa, but is able to control it by taking one-fourth of a grain of morphia daily. With the morphia she has but two movements daily. She is able to wash and dress herself and go about the building and yard. At every movement from the side there is a muco-purulent discharge from the anus.

This operation was first proposed by Littre, in 1710. He, however, suggested to make an incision in the left inguinal region. It was not put in execution until 1776, sixty six years later, when Pilhore, of Rouen, opened the cæcum through the right inguinal region. To avoid the danger of opening the peritoneum, and to place the artificial anus in a more convenient position, Collisen, in 1796, proposed reaching the colon by a vertical incision in the lumbar region; but we have no evidence that he performed it upon the living body. It remained for Amussat to place the operation upon a firm foundation, by making a transverse instead of a vertical incision in the lumbar region. The advantage of this plan over that of Collisen is, that it affords more room; the muscles cut across gape, and as the incision is in the direction of the vessels and nerves, they are less likely to be injured. Our pride in American, and especially in Philadelphia, surgery will not permit us to ignore the fact that Dr. William Ashmead, of this city, in 1838, opened the descending colon by a vertical incision without injury to the peritoneum, and was not aware until two years later that such a plan had been proposed by Collisen. Bryant modified Amussat's operation by making the incision obliquely or in line with the natural folding or creasing of the skin. This modification was followed in the case described above.

In performing the operation, the patient is placed in the prone position or slightly reclining toward the right side when the descending colon is to be opened. A large pillow or air cushion should be placed under the abdomen, the left lumbar region tense. Draw a line, with ink or tincture iodine, from a point ½″ posterior to the middle of the crest of the ilium, to the lower rib, which will indicate the normal position of the descending colon. An incision is then made down to the aponeurosis, from the external border of the erector spinæ mass, obliquely forward four or five inches, crossing the vertical line at its centre; the aponeurosis is cut through carefully, until we reach the anterior border of the quadratus lumborum muscle. Cutting through the anterior layer of fasciæ will usually disclose the mass of fat upon which the intestine rests in this situation. Care should be observed, to avoid going too far forward here, for fear of injuring the peritoneum; the hemorrhage should be controlled as the operator proceeds, and especially before the last layer of fasciæ is opened. When the layer of fat is broken through, the intestine will usually, as in the case above, protrude into the wound. When it does not, it may be distinguished by: 1st, its distention and greenish hue, when previously distended;

2d, the longitudinal and circular fibres may be recognized; 3d, Amussat suggested that the small intestine, when protruding, was subject to oscillation during respiration, which, from its more fixed position, does not take place in the colon; 4th, If the incision be as directed above, we can distinguish it from its position, and should it be empty or flaccid, we may search for it at the bottom of the wound; when it protrudes, it is well to rotate it toward the anterior spine, in order to reach the surface free of peritoneum. In all examinations, it is well to avoid introducing the finger toward the anterior surface of the intestine. Should the peritoneum be injured, Mason recommends to seize it as you would a bleeding vessel, and apply a ligature.

Having satisfied ourselves that we have the colon, it should be transfixed by two ligatures $\frac{3}{4}''$ apart, drawn out and secured to the integument, tow or lint placed on each side, and an incision $1''$ to $1\frac{1}{2}''$ in length, made by knife or scissors, between the ligatures, taking every precaution to prevent fecal extravasations. The opening in the intestine should now be attached to the integument by four or six sutures, and each end of the incision through the integument brought together.

It is usually recommended to fill the intestine with air or water previous to commencing the operation; where either is used air is undoubtedly the better, as there is less danger of soiling the surrounding tissues when the gut is opened. An important advantage gained is that it increases the extent of surface free of peritoneum. In the case related above no difficulty was experienced in securing the bowel, though it had not been previously distended.

The after treatment is very simple. It may consist of a cloth spread with carbolized oxide of zinc ointment, changed as the necessities of the case may demand, or a wad of oakum saturated with carbolized oil, as in the case above.

There is frequently a little pain or soreness in the side, from the inflammation and swelling of the wound and the stretching of the intestine; if severe it may be allayed by warm fomentations and a dose of morphia. In some cases obstinate vomiting has been the cause of death; this has been ascribed to the effects of chloroform, but as it has also occurred when ether was administered, it is probably due to some reflex influence from the solar plexus. An extensive prolapse of the intestine may take place, and it is well the patient should be warned of this danger, as he would be much frightened.

The operation would be indicated to the merest tyro, when there was obstruction of the bowel from cancer that could not be relieved by rectotomy, or in intractable strictures due to other causes, as syphilis injuries, chronic dysentery, etc.

It is also capable of affording great relief, as shown by numerous cases when the stricture is not so marked, but in which the patient is kept in agony by frequent passages over an extensively ulcerated rectal surface. The operation was first done by Mr. Pennell, for vesico-intestinal fistula in the male, restoring his patient to usefulness. Christopher Heath performed it in a female, for a similar difficulty. It has been performed for extensive recto-vaginal fistula and obstruction, from the pressure of tumors.

The objections to the operation may be pretty well brought under the head of: 1st, dangers. It certainly cannot be claimed that the operation is entirely free from danger, but the statistics show us that in the hands of a good anatomist and careful operator they are comparatively slight. 2d. Condemning the patient, for the remainder of his life, to the discomfort and inconvenience of an artificial anus.

This is an objection the patient or members of his family will naturally make, and is the one most frequently advanced by surgeons of little experience with the operation. On the other hand, the testimony of many patients and that of surgeons of long experience, is, that they do not suffer great inconvenience, but in many cases the bowels act with great regularity.

When we weigh the inconvenience suffered in the balance with the suffering allayed and life prolonged, we cannot but feel that it is more than justified by its results.

The earliest analysis of the results of this operation was by Cæsar Hawkins, in 35th volume of *Transactions* of the Royal Medical and Chirurgical Society of London, in which he gave a record of 44 cases, being all he could find up to 1853. Of these, 23 recovered and 21 died.

From 1853 to 1873 Dr. Erskine Mason, of New York, has collected 80 cases. In three cases the small intestine was opened, 74 the descending colon, 2 the ascending colon, by Amussat's method, 1 by Collisen's, and resulted, so far as known, in 54 recoveries and 23 deaths. The shortest period of survival after the operation was sixteen hours, the longest six years.

Dr. Agnew, in his late work on surgery, has added five cases to the list, and in a hasty examination of the literature I have 3 published and 2 unpublished cases, one by Dr. Maury, and the case above noted, to add to the list, making in all 134 cases, with 85 recoveries and 49 deaths.

If we take in consideration the fact that the operation in many of these cases was postponed until the patients were exhausted by long suffering, these results cannot be otherwise than encouraging.

In conclusion, I would express my indebtedness for the notes of the case to Dr. Bernard Berens, who, as Resident Physician, had charge of the case.

A CASE OF OVARIAN TUMOR; MALIGNANT; DOUBLE OVARIOTOMY; DEATH AFTER FOURTEEN WEEKS.

BY JOSEPH ROBBINS, M.D.,
Of Quincy, Ill.

Theresa R., aged twenty nine, unmarried, underwent ovariotomy April 3d, 1818. About five years previously the patient fell down stairs, the accident being followed by severe pelvic pain, extending upward into the hypogastrium. Under the care of her father, an aged and prominent physician, she kept the recumbent position for some time. No physical exploration was made.

After getting about she became subject to attacks of agonizing ovarian neuralgia, always present during the menstrual periods, but rarely at other times. Such was her condition when she came under my observation in the summer of 1876, during the last illness of her father. On his death, which occurred soon after, she came under my care. All medication designed to prevent the recurrence of the oophoralgia not only failed, but the attacks gradually increased in frequency, though those occurring at the menstrual period were the most persistent and severe.

No vaginal examination could be obtained until March, 1879, when the uterus was found to be anteflexed, and too low in the pelvis. Pessaries proved to be of no avail, being always found displaced, lying transversely to the axis of the vagina. By the use of tents the cramped and strictured cervical canal was sufficiently enlarged to admit a stem pessary, but it could not be borne.

On the 11th of June, the patient finally consenting to anæsthesia, a thorough exploration was made, in which I was assisted by Dr. R. W. McMahan, of this city. By conjoined rectal and abdominal palpation, a tumor was made out, which we decided to be ovarian, forcing downward and flexing the uterus. It being evident that the flexion could not be cured, with a view to strengthening the cervical canal as much as possible, bilateral incision of the cervix was resorted to, with apparently slight relief during subsequent menstruations, only two of which occurred afterwards.

The tumor steadily and quite rapidly increased in size, and the attacks of hypogastric pain became more frequent. On the 19th of November the abdominal distention, the discomfort and pain, calling for operative interference, and the patient not being ready to submit to ovariotomy, the tumor was aspirated, and one hundred and seventeen ounces of dark-colored fluid drawn off, with such apparently entire collapse of the abdomen as seemed to leave no room for doubt that we had to deal with a simple monocyst.

Although the general relief following the emptying of the cyst was considerable, the paroxysms of pain were but little less frequent, continuing to call for large doses of morphia to subdue them, so that for some weeks prior to the removal of the tumor the quantity taken weekly amounted to about a drachm. The tumor refilled rapidly, and before the operation the abdomen was larger than ever. The patient, although rather above the medium height, was naturally of a slight and delicate figure, and this was further reduced by long-continued suffering, until, at the time fixed by herself for the major operation, her weight, exclusive of the tumor, could not have exceeded eighty-five pounds. On the day before the operation the pulse was 116 ; temperature normal.

The operation, which was performed under carbolized spray, was begun at 11.30 A.M., with the immediate assistance of Drs. H. W. Kendall and R. W. McMahan. Present, and also rendering valuable assistance in various capacities, were Drs. E. G. Castle, M. F. Bassett, L. H. A. Nickerson, L. H. Cohen, William C. Pipins and E. B. Montgomery.

The abdominal walls were so attenuated that what was nipped up in the middle of the incision for the overlying fascia proved to be the peritoneum. I could scarcely believe that the abdominal cavity had been entered, but demonstrated it by carrying a probe upward and sweeping it to and fro past the umbilicus without obstruction. Adhesions were found to be general over the anterior and lateral abdominal parietes, but, save in two or three places of limited area, they yielded easily under the edge of the hand. The tumor, being seized and tapped, so far refused to empty itself that it was found necessary to carry the incision, originally four inches in length, well above the umbilicus. On attempting to lift the partially collapsed

tumor forward through the opening, it gave way, breaking off in its lower third, which proved to be composed of a grayish, friable substance, resembling brain tissue, but darker, and somewhat firmer nearer its outer surface, and was about five inches in diameter at the point of fracture. The rupture permitted the escape of some of the contained fluid into the abdominal cavity, together with a small portion of a jelly-like substance, of which the tumor contained a large quantity. I think no one present had any doubt at that moment of the malignant character of the growth; there was, however, no alternative but to complete the operation. Rapidly detaching the major portion of the tumor, the remaining solid portion was found to be firmly fixed in the pelvic cavity. It was removed, piecemeal, with the fingers, when the point of firm adhesion was discovered to be over the bladder, and there a portion of the sac was left, it being impossible to find any line of separation between it and the subjacent tissues. The tumor was found to involve the right ovary, and its pedicle was very small. The left ovary was diseased, resembling in appearance and consistence the solid portion of the tumor, but was only slightly enlarged. It was also removed. The pedicles were tied and dropped, the ligature being composed of two strands of surgeon's silk, waxed, but not twisted.

Troublesome oozing occurred from the site of an extensive adhesion to the right abdominal wall, and in the pelvic cavity, where it was so persistent that the abdominal incision was extended downward, in order to bring the source of it into view. At this point, too, a hand mirror to throw light into the cavity served a good purpose. The hemorrhage was finally controlled in the pelvic cavity by the hot iron, and in the abdomen by pulverized Monsel's salt.

The cavities were freely washed out with sponges dipped in carbolized water. The abdominal parietes were found deeply injected, particularly the right. The uterus was healthy.

The incision was closed with silver wire sutures, which included half an inch of the peritoneum on either side. No straps were required. It was dressed with a strip of carded cotton, saturated with carbolized oil, a light compress and a flannel binder. The dressing was completed at 2.15 P.M., two hours and three quarters from the commencement of the operation. The digital dissection in the pelvic cavity was very tedious, and the persistent oozing required much time to control.

During the latter stages of the operation death more than once seemed imminent. Two or three times the pulse became imperceptible at the wrist, and once the respiration so nearly ceased that Dr. Nickerson, who managed the anæsthetic, thought the patient dead. Drs. Bassett and Pipino, with their instruments already charged for such an emergency, promptly injected alcohol hypodermically, and she rallied, the stimulant effect showing itself almost instantaneously. Afterward it became necessary to repeat this, and the same happy results followed. Without it, I think death would have occurred while she was on the table.

Consciousness returned at 2.30 P.M., slightly anticipated by a hypodermic injection of half a grain of morphia. A like quantity was injected each succeeding half hour, until four doses had been administered, the abdominal pain being intense.

On being put to bed the pulse was one hundred and twenty-five and very weak, the surface cold, and the lips livid. She was warmly covered with flannel blankets and surrounded with bottles of hot water, and reaction came on pretty promptly, being fully established on my visit at 7.30 P.M.

Upon examining that portion of the tumor that had been preserved, that portion first detached and embracing the fluid-containing sac, I was led to hope that it might belong to the non-malignant dermoid family; for though no dermoid surface could be made out, within the substance of the more solid portion was a softened, almost fluid, oily centre, containing a mass of tangled hair imbedded in a fatty substance, and forming quite a large lump, as large as a small adult fist.

As a portion of the fluid contents of the tumor was lost externally, in the not wholly successful attempt to prevent their escape into the abdominal cavity at the time of the rupture, its weight could not be got at, but it was large enough to fill all the available space in the abdominal and pelvic cavities.

With the exception of insomnia at first, and persistent abdominal pain, the progress of recovery from the operation was very satisfactory The pulse, which on the second day ranged from 126 to 139, fell on the third to 108; below 100 on the fourth; below 90 by the eleventh, and below 80 by the twentieth; ranging for a month afterward between 72 and 86. The temperature was 99° F. on the second day; and for the two following months did not rise above 99.8, save for three days, the fourteenth, fifteenth and sixteenth, when it ranged from 99 in the morning to 100, 100.2 and 100.5 in the evening.

The catheter was used twice, but the third time its touch at the entrance of the urethra provoked a discharge of urine unaided, and the instrument was not again resorted to until the seventh day; its use was then continued most of the time until the fifteenth.

On the sixth day, complaint being made of the weight of the compress, the wound was examined and union found to have occurred throughout, except between the second and third sutures from the top—opposite the umbilicus—where there was a slight superficial gaping, although the deep-seated structures were firmly united. Three alternate sutures, beginning with the lower, were removed and straps substituted. The site of the gaping was also strapped. On the eighth day the remaining sutures were removed, union being at that time complete.

As before stated, the abdominal pain was persistent; and it was so severe as to require the free exhibition of opiates to make it tolerable. Following the four hypodermic injections of one-half grain each, given within two hours of the return of consciousness, she was directed to have one grain of morphia by the mouth every hour, until the pain was subdued, or until the respirations were reduced to ten per minute. Such a measure of relief was obtained from the last injection, that administration of the medicine by the mouth did not begin until 7 o'clock, from which time until 2 A.M. she got one grain every hour. The pain being then less severe, the interval was extended to two hours, until 8 A.M. The respirations did not fall below twelve per minute. The morphine was continued in the same quantity, the interval between the doses not generally much exceeding an hour, through the second day and night, without any apparent toxic effect. The pupils remained natural during all this time.

In the morning, the pain being less severe, the interval was extended to two hours during the third day, but in the evening was again reduced to one. Before midnight the pain was much ameliorated; but it still continued in such degree as to require grain doses of the drug at irregular intervals of from one to three hours during the three or four following days. By the eleventh day, but four doses were required in the twenty-four hours, and by the sixteenth but two. During this time there was no tympanites, but the abdomen was very tender to the touch. The sensitiveness gradually diminished, however, except over the hypogastrium, where it still remained.

A fair amount of nourishment was taken, the appetite gradually improving until she declared, about three weeks after the operation, that for the first time in years she was really hungry. The *morale* was always good, flesh and strength increased, and at the end of a month she was able to exchange her bed for the chair or lounge, sitting up a portion of each day.

The bowels were first moved, by enemata, on the thirteenth day. Two days previous an attempt was made to soften up their contents preparatory to evacuation, by giving a fluid ounce of Hunyadi water every four hours, but severe griping caused it to be discontinued. Movements were secured by enemata, until the eighteenth day (April 20th), when the first spontaneous evacuation occurred, which was attended with severe pelvic pain and followed by a sensation as of something remaining in the rectum. The rectal uneasiness subsided in a couple of days, but was followed four days later by vesical tenesmus and irritability, lasting several days. On May 7th there was an attack of distressing rectal tenesmus, lasting several hours, and similar attacks occurred daily until the 10th, when some scybala were voided The tenesmus then ceased, but pelvic aching continued. The bowels remained sluggish, with occasional small evacuations, until the 20th, when, after an enema of glycerine, a lump of hardened fæces, as big as a large orange, presented at the anus, and was partly dug away with the handle of a spoon and partly expelled by the efforts of the patient. Examination *per vaginam*, which was very painful, showed the rectum distended with hardened fæces, firmly impacted, and about six inches of the descending colon, similarly distended, could be felt through the abdominal walls. For the removal of this mass I gave large quantities of glycerine by the mouth (fluid ounce doses every two hours), with a view to its solvent effect, and larger quantities mingled with water, by enema, which were repeated daily. The expulsive efforts of the patient were supplemented by the spoon-handle in the hands of the nurse, and each succeeding day showed something gained. Finally, on the 28th, the last of the impaction passed away.

The pain did not subside, as I had hoped it would, with the effectual clearing of the bowels. There was a constant aching, and with every evacuation, whether consistent or loose, distressing tenderness; and on the 31st I was forced to record my conviction that there was malignant disease within the pelvis. Although taking ice freely from the first, she could not at any time after the operation take cold water in any considerable quantity without gastric pain.

On the 14th of May she first noticed a coincidence which afterwards persisted with almost constant regularity; the ingestion of food, even when it produced no gastric uneasiness, was followed by an immediate aggravation of pelvic pain. From this time on the appetite diminished, and by the middle of June she had more than lost the flesh and strength that had been gained. The skin was sallow, her general appearance cachectic; the pelvic aching continued; there were frequent discharges from the bowels, always small and tenesmic, and whenever the stools were consistent they were flattened; vesical irritability and tenesmus were almost constant symptoms. This condition of affairs continued with little variation until July 10th, when, at about two o'clock, A.M., she had an alvine evacuation of considerable size, and fainted, or nearly so. Soon after she had another, and was then seized with agonizing abdominal pain. The bladder had been very irritable, and she had several times passed a little water.

When I arrived, at 3.50 A.M., Dr. McMahan, who had also been sent for, was already present and giving her ether, and she was soon sufficiently under the influence of it to relieve the pain. At 4 o'clock I gave her nearly a grain of morphia, hypodermically, a like quantity having been taken *per orem*, about an hour before. At this time the pulse was almost imperceptible, and with great difficulty could be made out to be about 160 per minute. About twenty minutes after the injection of the morphine it became more perceptible, but soon failed again. Death occurred, without the quiver of a muscle, at 4.45 A.M.

Autopsy, eight hours after death.—Body emaciated to an extreme degree; rigor mortis well marked; cadaveric odor strong. The now tympanitic abdomen, on being punctured, emitted gas of an exceedingly fetid odor. The old incision was found to be very firmly united. Strong adhesive bands were met with anteriorly. The pelvis was filled with a confused mass of malignant growth, involving the uterus within it, and adherent to the vesical aspect of the cavity. It was the size of a medium adult fist. Only with the finger at the os uteri could the true relations of the tumor be made out. Its right and anterior superior portion had eroded, and broken down into a pulpy consistency, with fluid detritus floating about it. The whole mass appeared to be identical in color and consistence with the solid portion of the removed ovarian tumor. A lump of the same material, of the size of a large, plump fig, was found attached to a portion of the small intestine, which depended so as to come in contact with the pelvic mass. This lump was, however, entirely distinct, and was covered with its own envelope. A similar deposit, of the size and shape of a large bean, was found in the mesentery. The appendix vermiformis of the cæcum was bound down in the pelvic mass, while below the rectum was very much pressed upon.

Careful exploration with a small bougie failed to demonstrate any passage from the bladder into the abdominal cavity; but only by erosion of that viscus and consequent extravasation of urine could I account for the sudden onset of pain which preceded death; pain of such intensity, that in comparison with it all her previous sufferings seemed to be as nothing.

I will not prolong this record by comments, further than to say, that experience in this case did not afford any support to the received opinion, that the long continued free use of opium seriously lessens the power of the system to resist the shock of grave operations.

Hospital Reports.

BELLEVUE HOSPITAL, NEW YORK.

CLINIC OF WILLIAM H. THOMPSON, M.D.

Professor of Materia Medica and Therapeutics in the University of the City of New York.

At our last lecture, gentlemen, we were speaking of the diagnosis of a disease that has no symptoms of its own. I think it is important, clinically, to remember certain leading points with respect to each disease, and you may set this down as a general rule, that Bright's disease has no symptoms of its own, but has the symptoms of every disease you can think of, sooner or later in some of the cases that still come before you, and therein lies the difficulty of the diagnosis.

You may say, "Well, but what about the urine? Is not that distinctive of Bright's disease? Will not that give indications which will leave no doubt about the diagnosis?" It does when those indications are present, but it does not when they are absent. Every one of the changes of the urine which are considered characteristic of Bright's disease may be absent (except one?); for instance, albumen may be absent; and not only may be so, but ordinarily is so; absent in more than one half the cases, unless you examine a great many specimens of urine; when you do have it it is usually temporary; it does not continue throughout the whole history of the disease; you will find it disappear for a while and come again; that is, in the chronic cases.

Then again, about casts: they may be present or they may be absent; some of the worst cases of Bright's disease will give no evidence of casts until you have examined a great many specimens of urine. Hence, you may not be able to make up your mind, until you have examined the urine

for a good while. that there is no disease of the kidneys, except for one fact, and even that must be taken with qualifications; that is, the specific gravity. In proportion as the urine is more watery, contains less of the solids, is the presumption that the kidneys are not working properly. But still this may happen, and repeatedly does happen, without any disease of the kidneys; namely, in nervous diseases. Here you are very likely to have a great deal of watery urine of very low specific gravity. In diabetes insipidus, for instance, which is due to a nervous complaint (principally), we have an enormous quantity of water passed, almost as pure as distilled water. I have known the specific gravity down to 1.001 repeatedly, and I have known it down to 1.000; but there must have been something wrong with the urinometer. But lately Professor Arnold requested me to see a case with him in which the urinometer marked 1.000 for one or two days. The patient was passing pure distilled water. Now, these are cases that show us that occasionally the water leaks through the apparatus of the kidneys almost pure. They are not always cases of kidney disease, though I believe they are oftener cases of kidney disease than not, but sometimes they are due to nervous disease alone. It is a very common thing in cases of exhaustion of the nervous system from any cause to have found the urine of very low specific gravity without any trouble of the kidneys. So that, although I regard the specific gravity as the most certain test of disease of the kidneys, it must be checked by other considerations.

Kidney disease is probably the commonest cause of death in this climate, in adults. I think it is a more common cause of death than even phthisis. But the patient with Bright's disease will come to you with almost any kind of complaint that you can imagine, and it is, for that reason, very often overlooked, and the disorders which it may occasion in any particular organ, for instance, will be taken to be the disease present. Now, it is a great misfortune to do so, and to-day I will take up the different parts of the body as they will be affected by Bright's disease, and will illustrate to you how I come to the conclusion that it is Bright's disease that occasioned the symptoms.

First, let us take these two cases which were brought up from the surgical ward. I have not seen them before. but I am told they are cases of this affection. The first patient tells us he has been sick for twelve months; he came into the hospital on account of retention of water. He has swelling about his feet. He has cramps in the stomach; has not vomiting or purging; has a lightness in the head, some headache, but not very frequently. It first began to be affected with the commencement of his ailment, twelve months ago.

Now, you may practice for years without meeting with a case in which the symptoms complained of by the patient commenced with the urinary organs themselves. This patient is an exception. And here I may say that you will have considerable difficulty in persuading your patient to believe he has any trouble with the kidneys, because he has no idea that he could have a trouble so serious as he would suppose a kidney trouble would be, without having some pain directly referable to the kidneys. It is very difficult to make some believe that they have any trouble of the kidneys, just because they have never had in that region of the body a single abnormal sensation.

The next patient also came from the surgical ward. Eleven months ago he was operated upon for hip-joint disease, since which time the abscess has been open and running. After this running had continued for some time he noticed a swelling in his back, about his kidneys; then swelling appeared in the feet. Now here is another case that differs in its history, altogether, from any case we have had before. It is probable that an examination of his abdomen would reveal enlargement of the liver; and usually these patients pass a large quantity of dark-colored water; that is characteristic in this form of the trouble; that which comes on during prolonged suppuration, but notably suppuration of bone, or connected with disease of bone, I should rather say. It is lardaceous disease of the kidney, what has been termed amyloid disease of the kidney. It comes on very insidiously, and with conditions that are exactly reproduced in the liver. We have the same change occurring in the liver that we find in the kidney. Well, the first symptoms the patients will complain of will be, in the majority of instances, dropsy and great debility, and that is about all. They are exceedingly negative. It is not until the disease has progressed for a long while that you will begin to have those other symptoms relative to some distant organ of the body, either the brain, the stomach, the lungs, etc.

Now we will take up the different organs of the body, and show you how they may be affected by Bright's disease, and how you may reach the conclusion that the kidneys are at the root of the trouble, although you examine the urine and do not find positive indications of it.

First, the head. A patient may have a very severe headache due to Bright's disease, but so he may have from a number of other causes. The causes of headache are almost infinite. What, therefore, will be your reason for suspecting Bright's disease the cause of headache in any given case? If the patient never suffered from headache before it is a new story to him; but lately he suffers frequently from it; it is a suspicious circumstance. If along with it he has nausea, you have another suspicious circumstance; that, you know, occurs with sick headache also; but sick headache is an old story; the patient is accustomed to it; it is usually almost a life-long story. Hence a headache that is recent, and which produces nausea and vomiting, is very suspicious. Then the headache of Bright's disease very rarely occurs without being accompanied by some derangement of vision or some symptoms connected with the eyes. In some cases there will be failure of vision; yet that may be ascribed to the patient's age, for instance, as Bright's disease so commonly occurs in adult life. But there will be something different from failure alone in the presence of sparks or specks, as the case may be. I prefer to call them sparks or specks, for this reason; that sparks or bright-colored specks

mean that you have a congested, inflammatory condition of the retina; dark-colored specks, on the other hand, are simply indications of anæmia of the retina, or a state that is analogous to that which produces the darkness that comes over one when on the verge of fainting; there is that difference between the two; but you may have either the one or the other caused by Bright's disease. The patient will very frequently see a kind of halo or haze. It is very uncommon to have any disturbance of the important functions of the eyes so as to produce double vision or any disorder connected with single vision, either amblyopia or diplopia, etc.; but this other state, namely, haziness, a dim cloud and specks, occurring with headache, and that headache producing nausea, would lead me, if I did not find anything in the urine, to examine the rest of the patient's frame.

In the first place, I would very carefully examine the arteries of the body, to see whether they were thickened and had that sense of arterial fullness that we have spoken of. But there you would have to be somewhat guarded in your conclusion. In my own case, I have a great deal of dilatation of the left temporal artery; it is always larger than the right. It is because I have been subjected for years, at least thirty years, commencing in my early boyhood, to hemicrania. Now, this you will find frequently in sick headache, dilatation of the temporal artery on one side. But suppose the radial arteries are thickened and rigid; or if they are not thickened or rigid, but are overfull and have an incompressible pulse with the symptoms of headache before mentioned, I would think the patient's kidneys were not working properly, even though I found no albumen in the urine. I should want to keep him under further observation.

But another class of symptoms may come up quite different from headache. The patient may have an attack of great depression of spirits, taking somewhat the form of insanity. That is a very common thing in Bright's disease; that is, it is one of the things that occurs in this disease. I will narrate a case illustrating that.

Three months ago I was asked by two physicians in New Jersey to see a case which was obscure to them. The patient was a gentleman who had been very fleshy, and was losing flesh rapidly, so that within a comparative short time he was reduced in weight forty pounds. This his physicians supposed to be due to some form of insanity, because he had become very much depressed in spirits, and had been detected several times trying to take his life. On one occasion he tried to shoot himself. He complained of a constant sensation of uneasiness in his head and of constant insomnia; and he had been dosed with all the narcotics, to give him sleep, but his sleep had been very poor. Now and then he had attacks of nausea, and twice he passed a good deal of blood from the bowels, and was very much reduced thereby. The question was, what is the matter with him? They had examined the urine three times, but found no albumen. On examining him, I found a very small and contracted liver; and by the way, he had been a very temperate man all his life; he never had drank at all; but he had a very small liver. He had a large heart; the arteries were rigid. With the exception of that loss of blood from the bowels, which nearly caused him to faint, and the loss of flesh, and mental symptoms, he had no indications of disease. Now, I made up my mind that it was a case of meningitis, due to uræmia; that it was uræmic meningitis; that the man was suffering from chronic meningitis caused by disease of the kidneys. I could not examine the urine then with the microscope, but it yielded negative results to the test for albumen. One of the physicians had examined it before, with the microscope, but found no casts. It was of low specific gravity, 1.008. I believe I forgot to say, that when you find urine of low specific gravity you should consider that fact in connection with the quantity passed in the twenty-four hours. If at the same time the urine is of low specific gravity the patient be passing a small quantity in the twenty-four hours, as two or three pints, or a pint and a half, or only half a pint, as I saw recently in a case, you may know it has not a nervous origin; for urine of low specific gravity, of nervous origin, is large in quantity, never small in quantity. But where the specific gravity is low because of kidney disease, the quantity of urine may be quite small.

Well, I found this patient had a small liver. I knew he had a diseased kidney, and that his was one of those cases so common now, in which we could not tell from the urine whether or not he had kidney disease, when in reality he had the worst kind, namely, a very contracted kidney. The small liver undoubtedly meant small kidney. Now, that is a fact of considerable importance, to which the attention of the profession was directed by Dr. George Johnson, twenty years ago, that chronic diseases of the liver are almost always accompanied by the same kind of chronic degeneration of the kidney. If you have a fatty liver you are very apt to have fatty kidneys; if you have an enlarged, engorged liver, you are very apt to have a similar enlargement and hyperæmia of the kidney; if you have lardaceous disease of the liver, you have also waxy or lardaceous disease of the kidney; if you have cirrhosis of the liver, you are almost certain to have cirrhosis of the kidney. Hence the presumption may be taken, in nearly every case, that contracted liver is accompanied by contracted kidney; and that you have the influence of both diseases present to explain the symptoms of the patient. Now, that contracted liver was, of course, the cause of that great purging of blood which he had. He had a giving way of the capillaries in the portal tract, on account of the great embarrassment of the portal circulation through the liver. But his brain troubles were unquestionably due to the condition of the blood, to uræmic poisoning; for he had the character of chronic uræmic meningitis. Now, as we told you before, a patient with Bright's disease may have any serous membrane affected; one will have meningitis, another pleurisy, another dropsy of the tunica vaginalis testis, and so on. In this case we had chronic meningitis, which was shown by these symptoms, namely, sleeplessness and a very prolonged pulse, now and then irregular. It was a long pulse, not a quick pulse; and it would now and then stop and be-

come quite irregular, a symptom quite common in derangements of the head. But the patient, instead of having headache, had a diffuse sensation of distress in the head, not located in any one particular place; and this is quite a common thing in chronic meningitis. And lastly, that loss of flesh which does occur in chronic meningitis, but may, however, occur from other causes. I gave my opinion that the meningitis was not due to the disease of the liver, because meningitis and liver disease do not often go together, but meningitis and kidney disease do very often go together. The treatment was directed accordingly. The specific gravity of the urine should be increased. For more than four weeks no benefit was derived from mercury. He was ordered to be put under the corrosive sublimate, and to continue the iodine, which he was taking in very small quantities, increasing it. He had been fed very largely on meat, because he was weak. But this was stopped; he was to have nothing but farinaceous food and milk, and dates. He was confined to these, and they are very good articles of diet, by the way. Anybody can live on milk and dates, as the Arabs do. He was to take the corrosive sublimate a long time. It went on without any benefit to his symptoms until about the sixth week, when he began to feel much better. He began to sleep better, and the last time I heard of him he was improving decidedly. Now, I think it very probable that he will improve up to a certain point and then stop, and the disease will finally carry him off. That is the manner in which it affected him.

Another case will begin with sudden, positive mental derangement, and when it does, it will, of course, vary in its symptoms. Nearly always, however, the patients are taciturn and very obstinate. That is, at least, my experience with brain troubles caused by uræmia. They have a tendency to be taciturn and exceedingly set in their ways. They cannot be persuaded to do anything. One gentleman whom I was called to see I persuaded, with great difficulty, to go to bed, and after he got there he concluded he would not get up, not even to pass his motions. He did not like it because I tried to reason with him, and told him he ought to get up for that. He said I had told him he must go to bed, and go to bed he did, and now was going to stay there. Well, he did stay there four or five days; nothing at all could be done with him. He remained in a state of stupor for about four months, acting very much as if he were idiotic. He had a very pale, exsanguinated appearance; the specific gravity of the urine was very low, and contained a great amount of albumen and casts continually. That was eleven years ago. That man had lost his wife a few months before, and it looked very much as if he were going to follow her very soon; but instead of that he got well, took to himself another wife, and is in active business at present.

The next class of cases which we will consider are those of pulmonary difficulty. Among the commonest symptoms of Bright's disease is some trouble somewhere in the chest, usually pleurisy. The pleurisy is usually characterized in this way: you have but a moderate amount of fever, or inflammation, or of pain, and a very disproportionate amount of effusion. That is, comparing it with ordinary cases of pleurisy, there is less fever, less inflammation, less pain, and there is a great deal of water. If, therefore, a patient comes to you with difficulty of breathing, and you discover on examining him, what he has not mentioned in his history, the symptoms of pleurisy, it is a very suspicious circumstance. Several times have patients come to me, saying they had a slight cough and shortness of breath, which was about all, and I found quite a pleuritic effusion. Had it been a pleurisy with some other cause than Bright's disease, the patient would have done two things which are very characteristic, he would have pointed to a particular spot and then said, I have severe pain there; he would also have a fever.

Patients with Bright's disease also very commonly have a bronchitis. We have had one case here in which the cough was the first symptom, and it was very severe. Now, how is this bronchitis to be suspected as the result of Bright's disease? In this way: the dyspnœa is out of all proportion to the lung trouble that you can discover, and it is located over the line of both lungs. You will hear a great many fine crackling râles. The patient very easily gets out of breath, and has a tendency to get pale in the face, while a true bronchitic patient is usually suffused in the face and eyes. Paleness in bronchitis is to me always suspicious, and particularly if I find the upper portion of the lungs tolerably clear, and on passing downward toward the base of the lung find a good deal of fine mucous crackling on both sides. This is so common, indeed, that one authority says it is pathognomonic of Bright's disease. If you always find a crackling at the base of the lungs, never clear, it matters not whether the patient has a cough or not, it is suspicious. I have a patient now under my care, who has not coughed at all, that I know of, but over the base of his lungs I always hear crackling sounds. I heard them the first time when examining him for a cold; but after the cold passed away these sounds were still heard. I mention this case because the patient was under my care for over eighteen months without showing once a trace of albumen in the urine, and I had a great deal of difficulty in making him and his friends believe, against the opinion of two other physicians, that he had Bright's disease. For eighteen months I treated him for Bright's disease, although I never found any albumen in the urine, and I was said to be in the wrong. But finally he had typical dropsy, and plenty of albumen in the urine, and what was supposed to be an epileptic fit, but afterwards properly attributed by them to Bright's disease. The other two physicians had been judging, from the absence of albumen and casts, that it was not a case of Bright's disease; but sooner or later he had plenty of both. But during all that eighteen months he had those subcrepitant râles over the base of both lungs, without any heart disease; without any enlargement of the heart that was noticeable. There probably was some, of course, as would occur in the course of the disease.

Another fact connected with the lungs, which, when it occurs, you may put the case down at once as one of Bright's disease; that is, an attack

of asthma coming on for the first time. Here again, you see, it is not the symptoms, but their connections, which point to Bright's disease. A man is waked up after midnight, for the first time in his life, with difficulty of breathing, of an asthmatic kind. He never had any such turn before. If that is his story, he has Bright's disease, for nothing else will do that. And you will usually find then plenty of albumen in his urine; not always but nearly always. Or he has, for the first time in his life, a very bloody expectoration, in large quantity. Now, that is not a case of ordinary hæmoptysis, and yet it is hæmoptysis. Now, what is the difference? He is raising a great deal of blood. Well, the difference is this: he has a great deal of dyspnœa with it, whereas, ordinary cases of hæmoptysis are not accompained by much dyspnœa, except it may be caused by the flow of blood.

So asthma is perfectly characteristic of Bright's disease, if the patient has never had it before; hæmoptysis is perfectly characteristic of Bright's disease, if it occasion a great deal of dyspnœa; in other words, if it is a kind of suffocating asthma with spitting up of blood.

With reference to the heart producing symptoms that are characteristic of Bright's disease: the patient has a good deal of difficulty of breathing when he walks up stairs or when he walks fast. He has a way of telling you that it is directly under the sternum that the sensation is felt. It is not like as it is in other cases of enlargement of the heart giving dyspnœa, for these latter feel it all over the heart. But as a rule, in uræmic dyspnœa, connected with uræmic disease of the heart (you may call it Bright's disease enlargement), the difficulty is felt directly under the sternum. The patient feels as if a great stone or weight were under the sternum. You find out that the patient has a very strong heart; that he has a tremendous beat of the heart; and that it is considerably enlarged, but no sign of valvular disease. Now, what is it that can cause enlargement of the heart besides valvular disease? Simply dyspnœa with enlargement of the heart does not indicate Bright's disease; but dyspnœa with enlargement of the heart and no valvular disease, does signify Bright's disease. The heart is enlarged, not on account of trouble with the heart, but on account of trouble away off in the arterial system; difficulty of pumping the blood through the arterial system, because the arteries have been narrowed by the disease, either a nervous narrowing, common spasm of the arteries, or by actual thickening of the walls of the arteries themselves. The heart grows larger and more powerful, in order to overcome this resistance in the arteries, instead of to overcome some condition of its own valves which causes enlargement in certain other cases. But sooner or later you will have valvular interference in enlargement of the heart from Bright's disease, but not as a cause.

Now, with regard to the stomach. The condition of the stomach which is characteristic of Bright's disease is that it is unusual, that the stomach trouble is a new feature, that is, new to the patient. First and foremost is dyspepsia of a recent kind, with tenderness on pressure. The patient does not like to button his pants, his vest or coat, or wear anything drawn tightly around him, particularly after eating. He dislikes to eat certain articles of food, because they increase his distress. The stomach becomes more and more troublesome, and he comes to you with this story, that he is very bilious; very likely he throws up a quantity of perfectly clear, greenish bile, and he is getting so he throws up his food very readily.

Now, here, of course, you have dyspepsia; a very common thing; a chronic gastric catarrh; a very common thing; you have vomiting, also; another common thing; how is it that you suspect Bright's disease? By the fact that it has come on within a year or two, and previous to that the patient had no trouble at all with his stomach; had had a very good stomach; and you cannot trace it to his habits in the way of drink particularly. If, therefore, you have a case of severe dyspepsia, with vomiting and distress after eating, coming on in a man who is temperate and used to have a very good stomach, and who has not changed his mode of life in a way to abuse his stomach, you may suspect Bright's disease. Therefore, as a matter of routine practice, you should, when a person comes to you with dyspepsia, examine his urine. Again, a persistent diarrhœa should lead you to examine the urine. Dysentery is not so common in Bright's disease, and I have seen several cases that had been supposed to be Bright's disease dysentery when they were really due to cirrhosis of the liver.

Lastly, the general symptoms: they are mere loss of strength. A man comes to you saying he has been feeling weak and debilitated, and does not know what is the matter with him, but he is losing strength. Well, is that very distinctive of Bright's disease? Yes, if he is very pale. Loss of strength comes in this disease with anæmia and nothing else. The patient may have meningitis, but that does not affect the muscular system; he may have pleurisy, but that in itself does not affect the muscular system; he may have heart disease and yet not feel weak; but when he begins to become anæmic he complains of muscular weakness and debility, and that is significant of Bright's disease. It is surprising how many symptoms may arise from this disease, and persist for a good while, without the patient complaining of loss of strength. But when it does occur it is due to anæmia, and the characteristics of anæmia from Bright's disease we have already described.

Epileptic, Hysterical and Puerperal Convulsions.

It is pointed out by Dr. Oppenheimer, in the *American Practitioner*, that the above three varieties of convulsions are occasionally liable to be confounded. Either of the first two occurring in childbed would be apt to be, and in fact, have often been mistaken for those uræmic in origin. He further claims that epilepsy may be produced by the pregnancy; and adds that hysterical convulsions differ from epileptic convulsions only in degree, and should, therefore, be termed *epileptoid* convulsions.

Editorial Department.

Periscope.

Headaches and their Treatment.

Dr. F. A. Simmons, of St. Joseph, Mo., writes, in the St. Joseph *Medical and Surgical Reporter*, for October, 1880:—

This disagreeable and common affection is associated with so many dissimilar conditions, and originates from such a variety of causes—immediate and remote—that its pathology and treatment are more unsatisfactory, perhaps, than any subject in the whole range of medical practice. In England, when all other causes fail to account for an attack, it is called *gouty*. In America, it is *sick* and *bilious*—occasionally *rheumatic*—but never gouty. These terms greatly influence the ideas the profession have of the pathology of the disease and their plans of its treatment. It should not be considered as a disease of itself, but should be regarded as a painful expression of encephalic change, a symptom—associated, it may be, with various organic lesions—with hyperæmia, anæmia, hyperæsthenia, or with hyperacute sensibility to all impressions, especially those of a reflex nature, originating in causes connected with the bladder, uterus, disorders of the stomach or other organs, or those reflected from other distant parts. A knowledge of these conditions has a great practical bearing in the treatment of headache. The remedies suitable for one form may aggravate that of another variety. There is no safe, reliable, universal, panacea; no one drug that will cure all these conditions. The search should not be for specifics, unless in pathological culture and physiological research. The specific condition should be ascertained, and then the specific drug selected to alleviate the pain of that condition.

The headache of hyperæmia is associated with a determination of blood to the brain, and a fullness of its vessels. There is pressure exerted by it upon the dura mater and pia mater; and these membranes being acutely sensitive, pain is produced, with a feeling of constriction. There is heat of the head, redness of the face, throbbing of the carotids, fullness and force of the pulse, ringing in the ears, vertigo, congestion of the conjunctiva, contracted pupil, and in severe cases nausea and vomiting. As recumbency facilitates the afflux of blood to the brain, it generally increases the pain.

Relief may be sought by depletion, purgatives, cold applications to the head, ice water, ice bags, chloral hydrate in xx grain doses, bromide of potassium in xx to xl grain doses, and by ergota in teaspoonful doses of the fluid extract.

Those reduced by acute disease, by hemorrhages, leucorrhœa, prolonged lactation, malaria, and those affected with leukæmia, tuberculosis and chlorosis, have *anæmic headache.*

It is recognized by the history above given, by a slow, languid pulse, dilated pupils, cool surface, pale face, and by a look of weariness and depression.

The treatment requires quietude of body and mind, stimulating and anodyne remedies, ammonia, camphor, opiates, ext. guarana—ʒ ss to ʒ j; spirits—brandy, whisky, etc., during the attack; and iron, strychnia, quinia, arsenic, bathing, electricity, and nourishing diet to tone up the system during the interval.

In the hyperæsthetic headache we have excitement and a peculiar sensitiveness of the brain, that render it painfully cognizant of impressions that ordinarily would not affect it at all, as we have spasms and convulsions from slight noises—as the rattling of water—in similar conditions of motorial irritation, caused by brain poisoning from strychnia, hydrophobia, and other poisonous agents. The accumulation of *urea* in the system produces this irritable, painful, neurotic condition of the brain so favorable to headache. Some of the most severe and persistent headaches I ever saw were associated with Bright's disease of the kidneys. Other poisonous agents also affect it thus. This painful predisposition and impressibility is sometimes left by sunstroke. Sometimes it is the legacy of inheritance. Come as it may, or however produced, when this painful predisposition exists, slight exciting causes from without or pa[illegible] from within are sufficient to develop [illegible] find a good

Mental and bodily fatigue on both sides. This sun's rays, loss of sle[illegible] one prudence in diet, the excessive use of tea, coffee, tobacco, and spirits, may be mentioned as familiar examples. The irritations reflected from distant parts and organs, as those of the uterus, bladder and stomach, have been mentioned. This neurotic condition of the brain may be more or less present in all the varieties of headache. It may be associated with anæmia or with hyperæmia.

In the treatment, opium or its alkaloids, morphia, or codeia, when not contraindicated by some individual idiosyncrasy, is the surest and speediest remedy we possess to alleviate the attack. Hydrate of chloral in fifteen grain doses, repeated every hour or two till relief is obtained, is a valuable remedy, especially where there there is some hyperæmia. So, in the same condition are the Bromides, in full doses. Caffeine in two to five grain doses, in tea or coffee, fluid extract of guarana (Paullinia sorbillis) in one-half to one drachm doses, are pleasant and good remedies.

To prevent a return of an attack the system should be toned up during the interval and put in as perfect a state of health as is possible. In most cases tonics are indicated. Other organs should be carefully interrogated for sources of reflex excitability.

Treatment of Stricture of the Rectum Caused by Syphilis.

Dr. J. Williston Wright, of New York, says, in an article on stricture of the rectum, published in the *Medical Gazette*, October 16th, 1880:—

In the treatment of strictures apparently depending upon constitutional syphilis, where the rectum is obstructed by the presence of a deposit resembling that of a gummy tumor, the patient should first be etherized, then the surgeon should introduce two fingers of his right hand into the rectum, and proceed to break down the soft, friable material of which the stricture is composed. Bougies of suitable sizes should then be used at intervals of a few days, the parts kept clean by injecting weak carbolized water several times daily, to be followed each time by a small quantity of common black wash or weak solution of nitrate of silver. The patient at the same time should be carefully brought under the effect of mercury and iodide of potassium, while the general health is maintained by the use of liberal diet and tonics, such as iron, quinine and cod-liver oil. Yet, as I have already stated, specific remedies seem to have less effect than in almost any other of the late or tertiary manifestations of syphilis. If the fingers are not sufficiently powerful to break up the deposit, it can be effected with this instrument, which resembles the tri-valve speculum, except that its blades are less flattened and stronger. When closed the instrument is small enough to pass almost any stricture. By turning the handle the blades are expanded and the stricture divided. It is the instrument is powerful care largement of the in using it lest a rupture of [illegible] all over accident which has happened more than once in the hands of good surgeons.

If there is reason to suppose that ulceration of the bowel exists above the strictured point, nitrate of silver in solution, or other stimulating fluid, can be applied by introducing a small, flexible male catheter through the stricture and injecting the substance by means of a syringe attached to its outer end.

Treatment of Acute Laryngitis in Young Children.

Dr. E. Fletcher Ingalls, of Chicago, says, in a communication to the Chicago *Medical Journal and Examiner*, for October, 1880, on the treatment of diseases of the larynx:—

Acute laryngitis in young children requires more vigorous treatment than in adults, because of the small size of the larynx, and the greater liability to spasm of the glottis. In treating these cases the warm bath should be used at first, to relieve the engorgement of the mucous membrane and tendency to spasm. The atmosphere of the room should be kept moist by steam, and the temperature kept up to 80° F. or 85° F., and when possible, the little patient should be induced to inhale steam from the atomizer. Frequently, young children become very much alarmed by the atomizer, when brought close to their faces, but they will get some benefit from it though it is placed three or four feet away. A great deal of benefit will frequently be derived from warm applications, care being taken to keep the parts constantly warm and moist. For this purpose, poultices of flaxseed are as good as anything, or you may use cloths wrung out of hot water, or spongiopilin with warm water, which latter is an elegant application. Whichever of these is employed, it must be kept constantly hot, for if allowed to cool it will do more harm than good. If these cannot be kept warm, it is much better to apply dry cloths. Turpentine stupes to the neck have also been found beneficial. If there is much tendency to spasm, the compound syrup of squills may be given, or small doses of belladonna, which not only relieve the spasmodic tendency, but possibly have some specific curative effect on the mucous membrane of the throat.

If œdema comes on, you should make an effort to scarify the part; but generally this cannot be effected in young children; failing in this, by passing the finger over the base of the tongue, you will sometimes be able to tear the mucous membrane with the nail, and thus allow the serum to escape. If you cannot relieve the œdema, and the dyspnœa continues to increase, do not hesitate to resort to tracheotomy, which holds out very good chances for recovery.

In a few rare instances of acute laryngitis in young children, the dyspnœa seems to be due to inflammation of the posterior crico-arytenoid muscles, which are the abductors of the vocal cords. The glottis, during respiration in health, is a triangular chink; but with paralysis of these muscles, the cords are drawn together during inspiration, so as to greatly interfere with the ingress of air. In one case of this sort, reported by Dr. J. Solis Cohen, it was found that the application of ice bags to the neck every minute for about eight hours succeeded in inducing reflex respiratory movements, which carried the child over the critical period.

The Papaw Juice.

Mr. H. J. Bose, who, while on a recent visit to Jamaica, had his attention directed to a statement that *Papaine* had been found to be a vegetable peptonizing agent, obtained some of the juice, and the experiments which he has since made with it confirm this statement, and even show that it acts as a diastase. Says he, in a communication to the *Canadian Pharmaceutical Journal*, for October, 1880:—

The experiments which I have made on the effect of the juice on fibrin and albumen confirm the results of previous investigators; but I have also found that the dried juice possesses the property of converting starch into sugar, thus taking the part of diastase. I have not yet had time to follow up this subject, but, in the meantime, briefly indicate the experiments made, so that those who have more leisure may find ground for further research.

1. Five grains of starch was boiled in two fluid drachms of water, and when cooled to 100° F., five grains papaw juice added, and the temperature maintained. In half an hour the solution was quite thin, and in an hour iodine no longer gave a blue coloration.

2 and 3. The same quantities were similarly treated, with the addition respectively of five grains of glycerine and five minims of alcohol, with similar results.

4. Ten grains of starch, similarly treated, was

decomposed by the same quantity, after a little longer action.

5. Fifteen grains nearly all decomposed under the same treatment.

6. Five grains of starch, similarly treated, but allowed to cool, gave a similar result.

7. Five grains of starch, similarly treated, with the addition of three minims of acid. hydrochlor. dil., showed but a slight action after three days.

In using any of the ordinary tests for sugar, the fact must be borne in mind, that papaw juice itself contains saccharine matter, which must be determined before the conversion of the starch can be accurately ascertained.

Obstructed Labor the Result of Operation for Lacerated Cervix.

From the Transactions of the Obstetrical Society of New York, published in the *American Journal of Obstetrics and Diseases of Women and Children*, for October, 1880, we learn that at the meeting of the Society, held March 2d, 1880, Dr. J. E. Janvrin reported a case with the following history:—

He was called to see a woman who was being attended in labor by Dr. Winters. She was a multipara, thirty-six or thirty-seven years old, and had been in labor twenty-four hours, with tremendous pains. Two years ago she was operated upon at the Woman's Hospital, for lacerated cervix, and a portion of the vaginal wall was also removed in an operation for the restoration of the perineum. On making an examination, he found that there was no dilatation whatever of the cervix. It was so small that, for a long time, he was unable to find it, and when found he recognized only a pinhole opening. The hot-water douche was recommended and used, with the hope that it would soften the cervix, but at the end of three or four hours the condition of things was unchanged. Dr. Winters then administered chloroform, and Dr. Janvrin succeeded in passing a bistoury and cutting the cervix upon either side without difficulty, and then gradually stretching it with the fingers. Sufficient dilatation was obtained at the end of about half an hour to enable him to deliver the woman with forceps. The child was dead, and apparently had been for some days, as the cuticle readily peeled off. The special point of interest in the case was the sewing up of the cervix so thoroughly two years ago that there was no dilatation produced by powerful labor pains continued for over twenty-four hours. It was the only case of the kind he had ever seen.

Obliteration and Renewal of Brain Function.

Dr. Orpheus Everts, of Cincinnati, writes to the *American Journal of Insanity*, for October, 1880:—

Arrest and release, or re-assertion of a part of, if not all cerebral functions, is not infrequent; instances of the kind occur under the observation of every general practitioner. Suspensions of brain function, generally partial, are usually brief and alternating. Obliterations of mental function and renewals of the same, are rare phenomena.

The instance recorded in *The Brain*, for April, 1879, and copied in the *Journal*, for July, 1880, is exceedingly interesting. In over thirty years' observation, I have seen but one case.

Miss —— aged about thirty, unmarried, of ordinary intelligence and common school education, in fair health previous to attack, in the autumn of 1846 was seized with an intermittent, as I supposed, and took, by direction, three doses of sulph. quinine, of six grains each, at intervals of three hours. I found, on examination the following morning, my patient paralyzed on the right side, and unable to communicate. The next day I discovered dry gangrene surrounding the great toenail of the left foot, and extending up the extremity. The gangrene progressed quite rapidly, until a line of separation marked its arrest at upper third of tibia, in front, but reaching only part way up the fleshy calf posteriorly. The woman's general health had begun to improve, without any apparent mental capacity, however, and I amputated the leg, by circular incision over tibia, and transfixing muscles in the rear, cutting down and out, to secure flap. My knife cut through a sack of pus under the belly of the muscles, but the muscles and integument appearing healthy, I dissected away the pus sack, and dressed. Healing took place kindly, and the woman, in the course of a few weeks, became quite fleshy. The right paralysis disappeared gradually; but on the re-appearance of mental activity it was discovered that the woman, so far as mental phenomena were concerned, was a new-born creature. She had to learn everything *de novo*. She had no memory of previous existence or circumstances. She learned much more rapidly than an infant learns; but had everything to learn. I kept track of the case six years, but know nothing of subsequent history.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the Transactions of the State Medical Society of Wisconsin contains a "Contribution to a Knowledge of Fracture of the Rim of the Acetabalum, based on the Reports of twenty-seven cases, and Experiments on the Cadavera," by Nicholas Glenn, M.D., of Milwaukee.

——"Syphilitic Degeneration of Arteries as a Cause of Aneurism," is the subject of a paper by Norman L. Snow, A.M., M.D., of Albany, which comes to us in a reprint from the *Medical Record*, August 28th, 1880.

—— *Lippincott's Magazine*, for November, is noticeable for the beauty of its illustrations and the agreeable mixture of the useful and beautiful it serves up to readers.

——A reprint from the *Independent Practitioner*, for September, 1880, contains "Some Practical Suggestions in the Treatment of Diphtheria," by R. J. Dunn, M.D., of Savannah, Ga.

——*Godey's Lady's Book*, for November, has some admirable fashion prints, and a choice selection of prose and verse, calculated for agreeable reading in the home circle.

——*The North American Review*, for November, presents several telling political articles, giving both sides of the question, a paper on the coming revision of the Bible, by Dr. Crosby, and other solid reading.

——Dr. W. T. Councilman sends us, in the form of a reprint from the *Journal of Physiology*, a contribution to the "Study of Inflammation as illustrated by Induced Keratitis," being the prize essay of the Baltimore Academy of Medicine.

——"School and Industrial Hygiene," is the title of the twelfth and last of the series of American Health Primers, edited by W. W. Keen, M.D. It is from the pen of D. F. Lincoln, M.D., Chairman Department of Health, Social Science Association. The subject is one of great importance, and as it has been handled with the skill of a master, we do not hesitate to say that this volume is one of the best, if not the best of this most excellent series. No school teacher, or parent, or any one else interested in the education and physical training of the young should neglect to read it. Published by Presley Blakiston, 1012 Walnut Street, Philadelphia. Price 50 cents per volume.

BOOK NOTICES.

A Practical Treatise on Nasal Catarrh. By Beverly Robinson, A.M., M.D. (Paris), Lecturer upon Clinical Medicine at the Bellevue Hospital Medical College, New York, etc., etc. New York, William Wood & Co., 27 Great Jones Street. 1880. Cloth, 8vo., pp. 182.

Although we have been almost inundated lately with treatises on nasal catarrh, and excellent ones too, we cannot but think that this one will form a valuable addition to what has already been written on the subject. In a disease so intractable as the one under consideration, it is highly desirable to have the experiences of all who have had the opportunity to treat a large number of cases. We thus get a variety of views and opinions, which, because sometimes conflicting, will lead us to think independently, while still enabling us to profit by the failures and successes of others. The use of the nasal douche the author condemns altogether, recommending the substitution of syringes and atomizers. Even these should not be used longer than is necessary to prevent the formation and lodgment of hard masses of inspissated mucus in the nasal cavities, or to remove unpleasant odors. The chapter on prophylaxis and general remedial treatment of various forms of coryza is, in our opinion, unexceptionally good, and perhaps the more valuable, because the author's opinions differ in some respects from those of others. The book contains fifty-six engravings, illustrating the various instruments for examination and for treatment, together with the methods of using them, etc., etc.

Twenty-fifth Annual Report upon the Births, Marriages and Deaths, in the city of Providence, for the year 1879. By Edwin M. Snow, M.D., Superintendent of Health and City Registrar. Providence Press Company, Printers to the City. 1880. pp. 88.

This is a most complete and admirably gotten up statistical report. It begins with births, the number of which, during the year 1879, was 2522, or 24.49 per 1000 of population. In connection with this report everything relating to the proportion of sex, color, parentage, seasons, plurality of births, etc., is given; not only for the year 1879, but for the past twenty-five years as well. The number of marriages was 2142, or 20.80 per 1000 of population; and in the report on this subject the same thoroughness has been observed. The number of deaths was 2026, or 19.67 per 1000 of population. The greatest number of deaths occurred during the month of December (213); the smallest number in June (120). The chief cause of death was consumption, the ratio of death from this cause to the whole number being 14.52 per cent., the largest number occurring in January and October. Next came scarlatina with 12.49 per cent., and then pneumonia with 7.19 per cent. The greatest number of deaths from scarlatina occurred in December, and from pneumonia in January. It is gratifying to see that the number of deaths from intemperance was exceedingly small.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

FOR AND AGAINST THERAPEUTICAL NOVELTIES.

The mania for the introduction of new remedies shows no symptom of decreasing. It still appears to be in quite an acute stage. Some satisfaction may be derived from the fact that the patient—which in this instance is the profession—is aware of his condition. He occasionally swears and occasionally laughs at his affliction. The joke is passing around, of the doctor who was asked by a rheumatic subject whether he had heard of this great new remedy for rheumatism, so much praised by Professor So-and-so. "Certainly I have," replied the doctor, "and I am going to prescribe it for you this very day, as in a month it will be of no account at all." There is also the story told of one of our well-known clinical teachers, rather characterized for his love of novelties, who on one occasion addressed his class:—

"This, gentlemen, is evidently a case of malarial disease. We know, of course, that quinine or arsenic is effectual in this class of complaints, and their exhibition, therefore, would teach us nothing. Let us rather try the celebrated new remedy advocated by Dr. So-and-so, etc."

Evidently the editor of the *Western Lancet* has got to the swearing point. Somebody sent him still another wonderful product of Peruvian bark, to notice, which was just one more than he could stand, and he breaks forth thus:—

"When will this diabolism cease? and when will the traffickers in new remedyism ever let up in their schemes of crowding into the van their tiresome innovations, and endeavoring to compel physicians to prescribe and use their silly and useless nostrums?

"We trust that physicians will resent and disfavor this classic procession of meaningless remedies, and give no encouragement to the missionaries sent out for their introduction; for it is through the medium of our medical men that we shall thwart the bombardment of these damaging delusions."

It is a pertinent inquiry whence these new remedies come in such masses, and why they are so energetically urged upon the profession. Perhaps the profession is not yet aware that decidedly the minority of these compounds originate with physicians.

It is in one sense true that the patent medicine business is "played out." A proprietary medicine advocated by the profession can be introduced at a far less cost and bring in most handsome returns. A new compound is, for a considerable time at least, the property of the firm which introduces it; and as its popularity is tolerably certain to be short, the introducing firm has the cream of the market, and can have another one ready by the time the last one is waning in favor.

The profits are splendid. One of these novelties, the proprietors of which notify physicians that it is "introduced through the profession only," returned, so it is reported, over *one hundred thousand dollars net profit* in the year 1879. From $50,000 to $100,000 clear profit is raked in every year by several drug houses we could name, made almost exclusively off of new preparations and remedies introduced strictly "ethically." With such magnificent prospects ahead, no wonder the competition is active.

But we should not shut our eyes to the advan-

tages resulting. It is to the interest of these great firms to have their preparations stable, genuine, and manufactured in the most careful manner. They have ample capital to secure the best pharmaceutical and chemical talent, and they do so. American pharmacy, especially in its technical and trade features, is ahead of all others. Again; should, by any chance, a new remedy have real value—an unlikely, but still possible hypothesis—it is a great benefit to have such able and energetic houses ready to get it, and supply it in any practicable quantity, and of the best quality. There are also, no doubt, vast unexplored fields in the realm of remedial agents which these combinations of skill and capital are rapidly opening up; and it is still possible that a plant as valuable as the poppy or cinchona is awaiting its discoverer; that an agent as efficient as arsenic or iodine may yet reward the medical chemist. Such a discovery were cheaply purchased by the useless dosing of a hundred years of patients. It is also noteworthy that most of these new remedies are harmless, or comparatively so. The reasons are obvious. Dangerous remedies are exhibited in small doses; can only be sold in small quantities, and consequently yield but small profits. Good, big doses, spoonful doses, pay the pharmacist best, and he doesn't want ugly accidents. Hence these preparations usually obey the so-called "first law" of the medical art, "Do no harm." Perhaps, therefore, in using them, the physician occasionally escapes an indiscretion which, were he busying himself with the old stand-bys, might lose him his patient prematurely.

Again, the public, by a curious psychological process, is sure to take a prejudice against any remedy it becomes familiar with. How often must the physician hear, "Doctor, don't give me any quinine, or mercury, or opium. I can't bear them." Homœopathy owes much of its popularity to the inscrutableness of its mysterious pellets and powders, and the barbarism of its therapeutical nomenclature. Hence it is a good thing to have some new remedies at hand, even if they are mere disguises of old ones, like some of the new chalybeates. We really believe that the tendency to fly off to practitioners of irregular schools, as well as to the consumption of quack medicine, have been diminished by the liberal introduction of therapeutical novelties.

These may not all seem very noble reasons for regarding with a kindly eye the pharmaceutical activity at present reigning. It is a cynic who teaches the maxim, *mundus vult decipi; decipiatur*. But one often has to choose between uncongenial routes; and probably were the balance fairly struck, it were more to the best advantage of the profession and their patients to encourage experimental pharmacy than to unite in frowning down the current methods of rushing medical novelties on the market.

Notes and Comments.

Therapeutical Notes.

IODIDE OF ETHYL IN ASTHMA.

This new remedy is reported upon favorably. A writer in the Chicago *Medical Journal and Examiner* found the effective dose to be six drops, by inhalation. It "relieved the paroxysms, as if by magic, and no unpleasant symptoms followed its use."

IODIZED GLYCERINE.

Dr. Lamarude (*La France Méd.*, 1880, p. 279) recommends the following formula:—

℞.	Glycerini,	℥ x	
	Tinct. iodini,	♏xxx	
	Potassii iodidi,	gr. ss.	M.

Sig.—A dessertspoonful a quarter of an hour before each meal.

Under the use of this remedy the appetite returns, and constipation, when it exists, ceases absolutely. In the case of delicate individuals this formula may be modified as follows:

℞.	Glycerini,	℥ viij	
	Syrupi rubi,	℥ xiv	
	Tinct. iodini,	♏xxx	
	Potassii iodidi,	gr. ss.	M.

Opinions from Canada about Venesection.

The annual meeting of the Canada Medical Association took place last month. Among other subjects discussed was that of venesection.

Dr. Hill read a paper, in which he expressed the opinion that the lancet would yet be employed more than at present. He recommended bleeding, especially in the early stages of fever, in pneumonia and in puerperal convulsions.

Dr. Botsford sympathized with the views of the writer.

Dr. R. P. Howard said that modern physicians are much more successful in the treatment of pneumonia than those who lived in the days of bleeding. He believed that now-a-days the nervous element was more prominent—the condition of neurasthenia was more frequent—and thus a different treatment was required.

Dr. J. Campbell said that many persons had a strong feeling against bleeding, and this gave rise to reflections when a case ended fatally, and hence many physicians were thus deterred from employing venesection. He had employed it successfully in three cases of puerperal convulsions.

Dr. Lafferty said that many old-fashioned people blamed the doctor if he did not bleed.

Dr. Brush never saw venesection practiced. He stated that Dr. Austin Flint had an attack of pneumonia; his attendants advised bleeding; he repeatedly objected; finally, the distress becoming more urgent, he requested to be bled, which was done and he was relieved.

Dr. Osler had seen great benefit from bleeding in pneumonia. Relief was immediate. He would also recommend it in the early stages, if there was very high fever; and in some forms of chronic valvular disease, to relieve fullness of the right heart.

Medical Practice in Virginia.

A letter in the *Virginia Medical Monthly* gives a most gloomy and we doubt not quite correct account of the wretched condition of medical practitioners in that State. The writer says, "A practitioner of forty-five years' practice left thousands of dollars of worthless accounts to his bankrupt estate and his pauper children and grandchildren, and the benefactors of his loss care no more about these unsettled and unwritten obligations, than if gratitude and honesty and honor were nothing but empty names. Another large practitioner, of thirty years' practice, died without means to purchase his coffin; and a large proportion of the physicians of Hanover Co., Va., are at this day miserable paupers, having no means to purchase the necessaries and comforts of life; and the surviving doctors themselves are unable to obtain decent clothes, medical journals, instruments, and even licenses. Many of them have but a miserable *rosinante* to attend to their daily calls, and very few of them have a vehicle either for themselves or for their families."

The causes of this state of affairs are defined to be, 1st. The exemption laws of the State; 2d. Indiscriminate credit to patients; 3d. Lack of uniformity in fee bills; 4th. A false spirit of philanthropy.

Evidently the correction of this state of things rests with the profession, and by firm and unanimous action they can restore themselves to their legitimate financial condition.

Nerve Grafting.

Dr. J. Gluck, of Bucharest, lately brought before the ninth congress of the German Society of Surgery, at Berlin, some interesting results of experiments in nerve-grafting. He cut out a portion of the sciatic nerve of a fowl, and then removed a similar portion of the same nerve from the leg of a rabbit, and placed this in the leg of the fowl, uniting the two ends by sutures. The nerve united, and the paralysis caused, of course, by the excision of the piece of nerve was recovered from. He repeated the experiment, and exhibited the successful results, showing the fowls with full restoration of power. He was led to these experiments by the result of a case of nerve suture. Paralysis of the median had resulted from an extensive destruction of the tissue of the arm by gangrene. Dr. Gluck cut down on the radial nerve and found that part of the nerve was destroyed. He united the two ends by sutures, and the man regained the power of motion, which he had entirely lost. Of course, the experiments in nerve-grafting in animals do not warrant the expectation that a similar result could be obtained in the case of the human subject. It is well known that the union and regeneration of nerves occur with greater facility in the case of the lower animals than in man.

Treatment of Acute Alcoholism.

After a hard spree, most men suffer with nervous excitement, loss of appetite, and insomnia. For this condition, they use, in the Albany Hospital, the following mixture:—

℞.	Tr. opii deod.,	f. ʒj	
	Potassii bromid.,	ʒj	
	Ext. hyoscyami, fl.,	f. ʒj	
	Chloral hydrat.,	ʒ ss	
	Tr. capsici,	f. ʒ ss	
	Tr. aconiti rad.,	♏v	
	Spts. menthæ pip.,	f. ʒ ss.	M.

Sig.—Take one dose, and repeat in four hours, if patient is not asleep.

One dose will usually keep the patient asleep for five or six hours, and upon awaking, food will be generally taken with relish. The patient

is kept thoroughly under the influence of this medicine for two or three days; after this, some bitter infusion, with some food, is all that is needed.

The object to be gained is rest, thereby checking the excessive waste of nervous force which otherwise takes place.

If the excited condition, after being once controlled, is allowed to return, much time is lost in securing convalescence; and for this reason, a condition of sleep or sleepiness for the first forty-eight hours of treatment is favorable.

The Prophylaxis of Puerperal Convulsions.

This subject has been made a matter of careful study by Dr. A. Segur, of Brooklyn. His conclusions are thus expressed at the close of his article in the *Transactions* of the Kings County Medical Society:—

1. We should study the convulsions of puerperal women as a symptom solely, as we do the convulsions of all other persons.

2. The convulsions of puerperal women are in almost all cases a symptom of insufficient performance of renal function—whether due to acute Bright's disease or to a disturbance simply functional. They are simply one of a uræmic train of symptoms.

3. Then the preventive treatment of uræmia is the prophylaxis of puerperal convulsions, as at the setting in of the uræmia it is very often too late to avert convulsions.

4. A pregnant as well as a parturient woman should be considered a subject for responsible professional care, and particularly be watched with reference to the function of the kidneys.

Lactucarium as a Sedative.

From our own experience with the drug—and it is not as much used as it should be—we can endorse the following remarks of Mr. J. Foster Flagg, D.D.S., in the *Dental Cosmos*:—

The syrup of lactucarium, when well made, and I have found remarkable difference in this regard, is a delightfully calming, soothing medicament, one which induces a condition of quiet that permits rest and allays irritation, both physical and mental.

This, like the solution of the bi-meconate of morphia, may not produce sleep, and indeed the wakeful state of quiet is rather the more likely to ensue; but *it* is very acceptable, and with some patients preferable to somnolency, especially during the evening and earlier hours of the night.

The dose of syrup of lactucarium is from a teaspoonful for a child to a dessert or even tablespoonful for an adult, repeated in an hour or two, if required.

Iodized Cotton.

This is made by saturating cotton wool with iodine tincture and sun-drying. A writer in the *British Medical Journal* says of it:—

I was led to attempt its use where it was desirable for a prolonged period to obtain the maximum of absorbent stimulating action of iodine with the minimum of skin irritation.

In the rough method of painting iodine on the skin, the amount actually consumed is but small; yet, if an effort be made to push the treatment by either repeated painting or increased strength of solution, blistering occurs, necessarily followed for a time by cessation of its use. If, however, a layer of iodized cotton retained by a bandage be employed, not only is the skin placed in a favorable condition to slowly absorb the iodine as the confined perspiration gradually moistens and lets it free, but an additional factor is called into play by the application of equable pressure. In this way I have for years treated all cases where the external application of iodine is indicated, such as scrofulous and syphilitic affections of glands, chronic and acute synovitis and their sequelæ. In acute synovitis unusually rapid cure has appeared to follow where, after aspiration of the joint, absorption of small secondary effusion has been so aided.

Correspondence.

A New Method of Disposing of the Umbilical Cord.

Ed. Med. and Surg. Reporter:—

In the Reporter of October 2d I noticed a short note taken from some foreign journal, on "A New Dressing for the Navel," in which the writer states that he has dressed twenty-eight cases in the manner therein described, with entirely satisfactory results in every case. Some years ago, after considerable experience in obstetrics, I came to the conclusion that the directions given in the text books for the management of the cord and navel were in certain respects insufficient. I have, therefore, in my own practice, diverged somewhat from the prescribed method, and think that my treatment is an improvement upon that hitherto adopted; as to which, however, the reader can judge.

Immediately upon the birth of the child, and after it has given reasonably sufficient evidence that it has passed from the condition of an aquatic to that of an air-breathing animal, I

compress the cord between the thumb and the index and middle fingers of the right hand, and as close to the abdominal implantation as the surrounding structures will permit. At the same time, with the thumb and index finger of my free hand I press back toward the placenta, for a foot or more, all the blood in the vessels of the cord, and direct the nurse to place a first ligature at the point to which this backward pressure is continued. This having been done, and the circulation in the child having become well pronounced I free the cord from my right hand, and thus allow the hypogastric arteries to rid themselves of whatever pent-up blood they may contain (which, in many cases, is not inconsiderable), by giving the latter an opportunity to flow back into that portion of the cord from which the contents have been previously forced. If, upon examination, the cord is found to be even, and of the average size, the second ligature is applied at the usual point, and the now useless life line is divided. When, however, as is frequently the case, the cord is found to be not only unnaturally large, but also studded with nodules of considerable size, or pools of gelatinous fluid, I withhold the second ligature until after the cord has been divided, and all the gelatinous pools opened by passing through them the sharp point of the scissors (taking care at the same time not to sever or wound the vessels of the cord), and also until after the gelatinous fluid has been pressed out and absorbed by wrapping around the cord the corner of a dry towel, or a moist sponge, and compressing it firmly. The second ligature is then applied, mostly as a precautionary measure, inasmuch as hemorrhage has in a few exceptional cases occurred, and as I further consider it morally obligatory not to neglect a practice which is of itself so harmless, and yet so effectual against secondary hemorrhage.

What has now become the mere shred of what was previously a large cord, I wrap with just enough muslin to prevent the cord from adhering to the band or roller placed around the child: and also to prevent the moisture from coming in contact with the abdominal wall. This dressing, simple as it is, I direct to be removed once, at least, every twenty-four hours, the cord and its surroundings to be thoroughly washed, and a fresh and precisely similar dressing to be applied.

Since I adopted this plain and clean treatment, that is now for several years past, I have had no trouble whatever with the management of the navel, nor have I even had an ill smelling one. I am of the opinion that by thus freeing the hypogastric arteries of their contents, which otherwise would have to be done by nature, and much more slowly, a proper condition of the navel is far more readily secured than has ever been supposed possible.

In conclusion, I will remark, that I am quite convinced that the immediate comfort as well as the future well-being of the child would be greatly promoted, if both the wrappings for the navel and the bandage for the abdomen were allowed to remain in the nurse's basket.

HENRY L. HORTON.

Morrisania, New York City.

Treatment of Chronic Eczema.

ED. MED. AND SURG. REPORTER:—

In No. 4 of your journal, issued January 24th, 1880, I reported a case of chronic eczema, and requested some of your many readers to propose some remedies, as it was a very obstinate case. In No. 9, of February 28th, 1880, Dr. John S. Aydelotte, of Snow Hill, Md., replied, in a very well written article, suggesting the course of treatment and the remedies which had proven successful in his hands. And in the March number, on page 219, "J. C. C." very kindly suggests his treatment of the disease, without charge, if I will "report progress through your columns."

I take this privilege to return my thanks to the gentlemen for their advice and counsel, and to make my first report of the progress of the case.

It would be too tedious to give in detail the treatment of this well-marked and obstinate case of eczema, making its appearance on all parts of the external surface, in the ears, the eyes, and the system generally.

As stated in my previous report of the case, my treatment was mainly constitutional, by purgatives, alteratives, tonics and antacids. I desire to say to the gentlemen who so kindly gave me their prescriptions, that I did not adopt either, owing to the fact that the case began to improve permanently under the course I had prescribed for it before hearing from them. My treatment was, as above stated, pushing the cod-liver oil and Fowler's solution of arsenic mixed together. When the arsenic would begin to sicken the stomach, it was suspended for three or four days, and a dose of blue pill given at night, followed in the morning by an infusion consisting of senna, salts, Virginia snake-root and columbo, taken to move the bowels freely. After this, the arsenic was resumed as before. I also tried the fluid ext. of berberis aquifolium, as a substitute for the arsenic, but it did not answer the case. The only external application that was really beneficial was the benzoatin zinc ointment. I did not try the tar and calomel ointment recommended by "J. C. C.," not deeming it necessary. The case, I am happy to say, is entirely healed up and well, except a little burning sensation in the mouth, a symptom which prevailed during the whole course of the attack, and sometimes very aggravated. I am yet giving cod-liver oil in tablespoonful doses, three times a day.

K. S.

The Diploma Traffic.

ED. MED. AND SURG. REPORTER:—

A correspondent, in one of the late issues of your journal, says, on the subject of diploma selling: "I have long been satisfied, that this is a subject that County Medical Societies should not be expected to deal with, etc." He gives his reasons for societies not making "war on those bogus doctors:" and yet he fails to convince me that such societies should not do so. I claim that it is the duty of regular medical societies to use all honorable means at their command to silence all charlatans; and not only the socie-

ties, but the duty of every honorable member of the profession to educate, if possible, a confiding public in regard to the qualifications of all such pretenders. I agree with the Doctor, that we should have stringent laws governing the practice of medicine; not only a law of registration, but a law authorizing a competent board to examine each and every man who proposes to offer professional services to the public.

In this section of the country we are not only cursed with doctors who have bogus diplomas; we also have doctors who hold diplomas from medical schools, and yet are nothing better than ignorant pretenders. Some who have filled the places of hospital stewards in the war of the Rebellion came West and blazed forth as fully qualified. Such persons are not entitled to the etiquette of the profession. Our medical associations have members who are unwilling to take the mask off of those quacks that the people may know them by sight. Why? Because, forsooth, they are at times called in consultation with those quacks, and assign as a reason that the patients are worthy people and must have help; but I suspect that the fee is the motive power. Then the quack and his friends pass it around that Dr. A. said he was doing all any one could do, and that he (quack) was a bright star in the medical firmament. I claim that all honorable members of the profession, with the numerous medical societies, should discountenance all such actions. As to how a good law will work, we have an abundant evidence in the States of Illinois and Kansas. They have very stringent laws, and the result is that Missouri is flooded, as it were, by charlatans who have to leave the above-named States to escape legal penalties. It is said in Illinois there were driven out and silenced about eight hundred of such pretenders; in Kansas about four hundred.

J. L. Mizener, M.D.

Smithville, Mo., August 30th, 1880.

Large Doses of Morphia, Hypodermically.

Ed. Med. and Surg. Reporter:—

Under the head of "Notes and Comments," in the Reporter for October 9th, I notice an article calling attention to large doses of morphine administered hypodermically. A case is mentioned, taken from the *Practitioner*, where the dose given was six grains, repeated three times a day.

In the case of a patient lately under my care, I resorted to morphine hypodermically, to relieve the intense pain which accompanied dry gangrene of the feet; commencing with one-half grain doses, which I was obliged to rapidly increase, until the large amount of *twenty grains* was given at a *single* injection; for which operation a special syringe had to be manufactured.

Singularly enough, the progress of the disease was arrested, and the patient entirely recovered; but for a period of three years I gave her a single injection of from *twenty* to *twenty-five* grains daily, till she finally died, at the age of seventy-eight, from an attack of acute diarrhœa.

George A. Sterling, M.D.

Sag Harbor, Long Island, N. Y., Oct. 11th, 1880.

News and Miscellany.

The New York Medical Law.

We have been requested to publish the full text of the New York medical law, which we do this week, to the postponement of various other matters of news:—

An act entitled "An act to regulate the licensing of physicians and surgeons."

Passed May 29th, 1880;

The People of the State of New York, represented in Senate and Assembly, do enact as follows:—

Section 1. A person shall not practice physic or surgery within the state, unless he is twenty-one years of age, and either has been heretofore authorized so to do, pursuant to the laws in force at the time of his authorization, or is hereafter authorized so to do, as prescribed by chapter seven hundred and forty-six of the laws of eighteen hundred and seventy-two, or by subsequent sections of this act.

Sec. 2. Every person now lawfully engaged in the practice of physic and surgery within the state shall, on or before the first day of October, eighteen hundred and eighty, and every person hereafter duly authorized to practice physic and surgery shall, before commencing to practice, register in the clerk's office of the county where he is practicing, or intends to commence the practice of physic and surgery, in a book to be kept by said clerk, his name, residence and place of birth, together with his authority for so practicing physic and surgery as prescribed in this act. The person so registering shall subscribe and verify by oath or affirmation, before a person duly qualified to administer oaths under the laws of the state, an affidavit containing such facts, and whether such authority is by diploma or license, and the date of the same, and by whom granted; which, if willfully false, shall subject the affiant to conviction and punishment for perjury. The county clerk to receive a fee of twenty-five cents for such registration, to be paid by the person so registering.

Sec. 3. A person who violates either of the two preceding sections of this act, or who shall practice physic or surgery under cover of a diploma illegally obtained, shall be deemed to be guilty of a misdemeanor, and on conviction shall be punished by a fine of not less than fifty dollars nor more than two hundred dollars for the first offence, and for each subsequent offence by a fine of not less than one hundred dollars nor more than five hundred dollars, or by imprisonment for not less than thirty days nor more than ninety days, or both. The fine when collected shall be paid, the one-half to the person or corporation making the complaint, the other half into the county treasury.

Sec. 4. A person coming to the state from without the state, may be licensed to practice physic and surgery, or either, within the state, in the following manner: If he has a diploma conferring upon him the degree of doctor of medicine, issued by an incorporated university, medical

college, or medical school without the state, he shall exhibit the same to the faculty of some incorporated medical college or medical school of this state, with satisfactory evidence of his good moral character, and such other evidence, if any, of his qualifications as a physician or surgeon, as said faculty may require. If his diploma and qualifications are approved by them, then they shall indorse said diploma, which shall make it for the purpose of his license to practice medicine and surgery within this state the same as if issued by them. The applicant shall pay to the dean of said faculty the sum of twenty dollars for such examination and indorsement. This indorsed diploma shall authorize him to practice physic and surgery within the state upon his complying with the provisions of section two of this act.

SEC. 5. The degree of doctor of medicine lawfully conferred by any incorporated medical college or university in this state shall be a license to practice physic and surgery within the state, after the person to whom it is granted shall have complied with section two of this act.

SEC. 6. Nothing in this act shall apply to commissioned medical officers of the United States army or navy, or of the United States marine hospital service. Nor shall it apply to any person who has practiced medicine and surgery for ten years last past, and who is now pursuing the study of medicine and surgery in any legally incorporated medical college within this state, and who shall graduate from and receive a diploma within two years from the passage of this act.

SEC. 7. All acts, or parts of acts, inconsistent with the provisions of this act are hereby repealed.

Items.

—Melohiah, a Choctaw princess, died at Hoyt City, in the Indian Territory, the other day, at the great age of one hundred and fourteen years. She had thirteen great-great-grandchildren. She had been addicted to the inordinate use of tobacco for one hundred and five years.

OBITUARY NOTICES.

G. F. STEWART, M.D.—At a meeting of the Physicians of Wythe Depot, Shelby County, Tenn., the following resolutions of respect and condolence were adopted:—

WHEREAS, It has pleased God to remove from our midst, and from a life of usefulness, our esteemed brother of the Profession, Dr. G. F. Stewart, and while we bow in humility to the dispensation of the most High and Triune God, we cordially give expression to our sorrow in his death;

Resolved, That the medical profession in this vicinity are moved with deep regret by the death of so faithful and useful a member.

Resolved, That in this event we are in remembrance of his earnest devotion to our profession and to humanity, which stimulates us to increased energy in the discharge of the duties that rest upon us as physicians and citizens.

Resolved, That he was moral, kind and attentive to the profession of his choice; and the afflicted in this community always found in him a kind and considerate physician.

Resolved, That we do deeply sympathize with the bereaved wife, relatives and friends; and that a copy of these resolutions be furnished the MEDICAL AND SURGICAL REPORTER, of Philadelphia, for publication; and that a copy be presented to the wife of the deceased.

All of which is respectfully submitted:

B. F. O'DANIEL, M D.,
L. L. BATTLE, M.D.,
C. M. STEWART, M.D.,
J. F. BONE, M.D.,
W. B. BATTLE, M.D.,
J. P. DUGLASS, M.D.

—John Newton, Jr., M.D., whose whole life and soul were given to the physical and spiritual healing of the lepers in North India, died at Sabbathu, July 29th, of cancer in the stomach.

—Dr. Wilms, one of the most celebrated surgeons of Germany, died recently, from blood poisoning, consequent upon an accidental cut while performing an operation.

—Dr. Montgomery Chambers died recently, in this city, at the age of eighty-five. He was a practitioner in medicine for sixty years, the most of the time in this city, and was very highly esteemed. He made a number of contributions to the literature of medical science.

QUERIES AND REPLIES.

Dr. T. H. F., of Cal., inquires whether there is such an article as rubber underwear used in the treatment of lepra, and if so, whether it has proved beneficial, and where it can be obtained.

Ans.—Some articles on the subject appeared in the REPORTER a couple of years ago, but it does not appear to have come into much use, for some reason or other. Perhaps some of our readers may know more about it.

MARRIAGES.

ANDREW—SHARP.—At Morristown, N. J., Sept. 15th, by the Rev. Dr. Erdman, assisted by the Rev. Bromwell Andrew, of the Newark Conference, father of the groom, H. B. Andrew, M.D., and Emma Louise Sharp, both of Morristown.

JONES—McGRATH.—On Wednesday, October 13th, 1880, at St. John's R. C. Church, by the Rev. P. R. O'Reilly, Alfred Jones, M.D., of Chester County, Penn., and Kate, daughter of John McGrath, Esq., of Philadelphia.

DEATHS

CHAMBERS.—In this city, on Sunday, 10th inst., Montgomery Chambers, M.D., in the eighty-fifth year of his age.

MARKLEY.—In this city, on the 8th inst., Juliet E., wife of Dr. A. D. Markley, in the forty-first year of her age.

THOMSON.—In this city, on the 6th inst., Dr. James W. Thomson, in the seventy-ninth year of his age.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1236.] PHILADELPHIA, NOVEMBER 6, 1880. [Vol. XLIII.—No. 19.

Original Department.

Communications.

A CASE OF NEURALGIA OF THE FIRST BRANCH OF THE FIFTH PAIR, OF SIX YEARS' DURATION, CURED BY DUQUESNEL'S ACONITIA.

BY DR. M. LANDESBERG,
Of Philadelphia.

Mrs. B., thirty-five years old, had been suffering from trigeminal neuralgia for over six years previous to her coming under my treatment for progressive myopia. The first attack occurred in the summer of 1873, lasting for over sixteen weeks. From this time paroxysms were repeated with unabated violence, at intervals of two to four weeks, usually attacking one side of the face. In some instances the affection kept on for several hours only, in others several days or even weeks. All the different kinds of remedies to which the patient recurred were of no avail. They did neither check the morbid process nor break the violence of the paroxysms.

Patient is of nervous temperament. Mental agitation was one of the most prominent causes of the paroxysms.

During my treating her for progressive myopia I had repeated occasion to observe, from the very beginning, the attacks of trigeminal neuralgia. The prodromal symptoms were slight photophobia and the appearance of a small ring of enlarged vessels around the cornea. Then ciliary neuralgia set in, bearing the features of genuine cyclitis. One spot of the upper ciliary region, outside from the superior muscle, became tender to such a degree that the slightest touch produced the most agonizing pain and intense symptoms of irritation. The latter rapidly increased in the further course of the affection. The upper lid and its surrounding parts became enormously swollen and puffy, and intense chemosis of the conjunctiva of the eyeball developed. Pupil became extremely contracted, yielding but very slightly to atropia. The pain extended over the whole head. The œdematous parts were flushed, moist with perspiration, and showed increased temperature. In rare instances the lower lid and its surrounding parts also showed slight serous infiltration. Intraocular pressure and background of the eye remained normal. Vision was not impaired.

Induced by Dr. E. C. Seguin's paper on the treatment of trigeminal neuralgia, by Duquesnel's Aconitia, I tried this agent on my patient. The form for administering was as follows:—

℞.	Aconitiæ (Duquesnel's),	gr. ¼	
	Glycerinæ,	ʒj	
	Alcohol,	ʒj	
	Aq. menth. pip.,	ʒ ij.	M.

Sig.—One tablespoonful three times a day.

The therapeutical effect was striking. Perfect recovery was obtained after the patient had used two bottles of the prescription.

Eighteen months elapsed, during which period the patient enjoyed perfect health, when her right eye suffered injury by a blow, which caused intraocular morbid alterations. The exterior of the eye remained normal. On the third day after the occurrence the patient complained of tenderness of the eyeball. On examination, I found one spot of the upper ciliary region tender to the touch. I at first considered this tenderness as a consequence only of the lesion. On the succeeding days the pain became intense,

photophobia and lachrymation set in, and slight serous infiltration of the conjunctiva of the eyeball developed. There was no doubt that I had to do here with a relapse of trigeminal neuralgia, provoked, likely, either by the blow itself, or by the mental agitation of the patient consequent upon it.

I recurred to aconitia, which checked the paroxysm in its very beginning.

1912 *Arch street.*

FLAYING OF THE VOCAL CORDS.

BY DR. CARLO LABUS, OF MILAN,

Lecturer on Laryngoscopy in the Royal University of Pavia, Corresponding Fellow American Laryngological Association, etc.

Translated from the Italian and read before the Philadelphia Laryngological Society,

BY CHAS. E. SAJOUS, M.D.,

First Assistant, Laryngoscopic Department, Jefferson College Hospital, Fellow American Laryngological Association, etc.

In a pamphlet of twenty-four pages, Dr. Labus introduces a novel operation for the more rapid and permanent cure of chronic congestion of the vocal cords. The first pages of the monograph are devoted to the causes giving rise to the affection in question. After describing in a very clear manner the operation, the author gives a list of twelve cases (among whom are some prominent singers), showing results of a very satisfactory character.

The length of the paper not allowing its publication in full, the following extract will serve to show its principal points:—

Considering the facility with which traumatic endolaryngeal lesions are cured, frequently without even leaving the least trace of the trouble (as I was able to convince myself in sixty cases of laryngeal tumors extirpated laryngoscopically), and guided by the criterion of analogy, that when loss of substance occurs in the superficial strata of mucous membrane repair takes place completely, the idea occurred to me to attempt the removal of that part of the membrane which had become hyperplastic, and wait for the formation of a new tissue, identical with the normal, and possessing all the qualities requisite for perfect phonation. To obtain this result, it became necessary to create a traumatic lesion, avoiding unnecessary laceration, thereby diminishing the chances for excessive reaction, which would compromise an otherwise normal and rapid cicatrization. I thought to effect this by stripping the cord of the hyperplastic tissue covering it; using for that purpose an instrument such as Tuerck's polyp-crusher, or a toothed forceps of some kind, with lower branches turned before or backward.

To succeed in performing so minute an operation, it is necessary that the patient acquire perfect toleration of the instrument; to obtain which I resort to repeated manipulation. This having been obtained, Türck Schrotter's method of anæsthesia may be used for the operation, but I am not disposed to advise it, the inflammatory reaction secondary to the application of chloroform retarding the recovery.

The operation is performed during inspiration; the cords being then separated, the hyperplastic mucous tissue presents itself so that it can easily be seized. If the inflammatory process extends over more tissue than the instrument can embrace, it becomes necessary to strip the whole affected extent. The operation is said to give but little pain. For the moment, the voice becomes clearer, but very soon it becomes weaker and weaker, until complete aphonia exists, which lasts two or three days; this is caused by paralysis of the superior fasciculus of the thyro-arytenoid muscle. The consecutive reaction is but very slight; the cords present slight redness and turgescence, the flayed space remaining perfectly white. As a general thing the lesion becomes cicatrized in three or four days, and nothing remains but a slight turgescence, which gradually disappears. The voice returns with all its delicacy and purity.

The consecutive treatment can be said to be negative Pain, a slight burning sensation lasting a few hours, requires but little attention. Abstinence from irritating drink, smoking, and from breathing a vitiated atmosphere; or exposure to causes giving rise to coryza or bronchial catarrh, is necessary; but above all, silence must be observed the first few days, in order to give the organ complete rest. Local medication, producing irritation, retards recovery. If, however, the reduction of the turgescence should be too slow, then only very weak astringent inhalations may be advised. The material condition of the cord operated upon does not allow the least exercise at singing for at least one month after the cure of the lesion, to secure complete absorption of the exudation and coaptation of tissues.

The idea of resorting to the above process came to me seven years ago, while having under treatment a celebrated singer. The mucous membrane of the middle third of the right vocal cord was raised, so to say, detached, rendering the voice impure, and strongly compromising a brilliant career. A local astringent treatment re-

lieved her enough to allow her return to the stage, but the improvement was but momentary. Impressed by this, I decided to attempt denuding the cord of its hyperplastic tissue in cases of like nature, and very soon an opportunity presented itself in the person of M. Roussel, a tenor. This artist, after a career of eight years, found himself forced to abandon singing, his voice having become defective. After a cold contracted some time before, his voice had remained impure. On the margin of the right vocal cord and on its anterior third the mucous membrane was somewhat relaxed and projecting, and during phonation vibrated with the cord. Having tried, without result, insufflations of astringent powders, I proposed the extirpation of the loose portion of the membrane, which was accepted as a last resort, a year's continuous treatment having proven ineffectual. After four days' manipulation I was able to touch the cord without exciting reflex action. On September 22d, 1874, I prepared myself for the operation, and so as to obtain the highest tolerance possible, I resorted to local anesthesia. Following the proceedings described above, the operation was performed without difficulty; the reaction was almost nil; the voice weakened for a day or so, but on the third had returned, and continued clearing so rapidly that in a week he could be considered as cured, the larynx not presenting the least trace of the lesion, and the margin of the cord being perfectly straight and smooth. As to his voice, in filling an engagement the following December, it was characterized as "admirable," by the papers of the day, and compared to that of Rubini.

In February, 1875, Signora Rosa Bellincioni, contralto, came to me, complaining that during the past year the least prolonged singing caused great fatigue and lowering of the voice. The right vocal cord was somewhat tumid and pinkish in its anterior and middle third, and its margin projected in the rima glottidea at certain points. I prescribed a local astringent treatment, and did not see the patient until the following February. She then related that she had followed my treatment, without advantage; that her voice was worse notwithstanding, since the year before she could reach G fourth octave, and now she could only reach E flat fourth octave; and that in that state she could absolutely not sing. On examination, I found the same tumefaction as the year previous, only increased, and of a bright red. The operation being proposed and accepted, twelve days' manipulation of the larynx enabled me to master the organ so as to be able to perform the operation without anæsthesia. The voice instantly became clearer. There was no reaction, not even lowering of the voice. In twenty days the cord was perfectly white, and its border smooth and straight; the voice was very clear, and she could reach F sharp fourth octave. One month later it had taken its normal extension.

In May, 1876, Signora Flora Mariani, mezzo-soprano, came to me suffering with catarrhal pharyngitis, and stating that since winter her voice did not respond to her requirements; that she could not attack and sing in high register; and that it had lost its clearness. She had overused her voice; had sung parts too high for it; and worst of all, had sung while under the effects of a cold. Besides the pharyngitis, I found both vocal cords reddish and tumid. I advised her rest and the use of a local astringent treatment. One month later she again called, with full intention to undergo thorough treatment. I began with astringent insufflations, with notable advantage at first, the left vocal cord, in fact, returning to its normal condition. After twenty days' treatment, not noticing much progress, the right vocal cord retaining its tumid condition, and encouraged by the results obtained in the cases narrated above, I proposed my new operation; that is to say, to strip the cord of the hyperplastic tissue which did not show a tendency to reduction. After a week's manipulation, on the 9th of July I extirpated the whole portion of tumid mucous membrane at once. The reaction was nil. At the end of two weeks her voice in speaking was natural. I did not allow her to sing before a month after the operation, the cord not presenting then the least trace of the lesion. Her voice was, in fact, admirable, and her high notes were as clear as before her illness. After a month's exercise at singing, the voice, instead of improving, began to weaken and lose its clearness. On examining the larynx I found the cord operated upon perfectly normal, white, smooth, with straight edge, but the left vocal cord was tumid and red throughout its whole extent. No doubt, the exacerbation of the same inflammatory process I had found on her first visit existing in both cords, but which had been temporarily mastered in the left by astringent medication and rest, had reappeared on reassuming singing, the cord operated upon having resisted the labor imposed upon it. Naturally, the enthusiasm engendered by the success of the first operation, led her to accept a second one very readily. In a few days I was able to introduce my forceps and extirpate the mucous mem-

brane covering the left cord throughout its whole extent, which was done in three different applications, the instrument being too small to embrace it over its whole length. The pieces of mucous membrane were submitted to the eminent histologist, Prof. Bizzozero, who recognized them as composed of epithelium, a thin layer of connective tissue underneath, pervaded with a few blood vessels. This time there was marked hoarseness, but in ten days the cord was in its normal condition. A month later the voice had resumed its facility in attacking pianissimos, while the "notes piquées" were true and clear. Very soon after, she started for Venice, and filled an engagement with great satisfaction. I saw Signora Mariani a year later, and again this Spring, and I was able to observe the perfectly normal condition of the organ laryngoscopically, while her voice was pure and metallic.

In autumn, 1876, came to the Ospidale Maggiore a chorus singer, Angela Allini, belonging to the Scala. Her voice, that of soprano, had become coarse, almost masculine, this having been brought on by overwork, especially while the organ was indisposed. A laryngoscopic examination revealed a fact which I had occasion to observe once before in a singing artist; besides the usual redness and thickening there was on the superior layer a long white stria running longitudinally, and resembling an atheromatous patch. After six days' manipulation, I extirpated the superior mucous layer of both cords.

Forced by poverty to enter upon her duties sooner than I desired her to do so, the patient resumed her labors at the end of a week. She sang through the whole carnival, the result being merely a slight weakness in tone and a slight redness of the cords; but these were not in the least tumid.

In September, 1877, Dante Del Papa, a tenor, came to the Hospital complaining of hoarseness. I found the right vocal cord congested and swollen. Not producing any relief with astringent applications, I performed the operation, with entire success. The reaction was very slight the voice being hardly veiled at the end of three days. After a short period of rest the patient returned home, and shortly after I heard that he was filling an engagement with entire satisfaction.

The following are the conclusions which I believe to be able to advance:—

1st. Catarrhal inflammation of the larynx is frequent among singers.

2d. Said inflammation has for its cause, besides rheumatic diathesis, the abuse of the functions of the larynx, and its use in pathological condition.

3d. It easily passes to chronicity, localizing on the vocal cords, these bearing the brunt of the functions of the organ and resulting in hyperplasia of the epithelial stratum and of the adjoining mucous layer.

4th. The result of this inspissation of the mucous membrane which invests the cords is an alteration in the voice, very often only noticeable during singing, but sufficient to impede the artist in exercising his profession.

5th. The treatment by topical applications is long, seldom giving rise to complete cure; oftener produces but a short amelioration, and in most cases fails completely.

6th. The process of flaying is not only innocuous, but gives more complete and lasting results, and that in shorter time, constituting the true radical treatment of hyperplastic inflammation of the vocal cords.

HIP-JOINT OPERATION.

BY G. GLANVILLE RUSK, M.D.,
Of Baltimore, Md.

In the early part of May I visited Augustus Moore, colored, aged thirty years, mariner by occupation, who informed me that he had been suffering for three months, and bed-ridden about one month, owing to the presence of a growth occupying the inner side of the right leg, which had commenced as a subcutaneous lump near the knee. He had been ordered a variety of applications for the purpose of "bursting" it. He desired me to evacuate the matter at once, as he was unable to endure the agony longer. Upon inspection I observed a tumor, in which there was neither fluctuation nor pulsation, involving the anterior femoral region of the right leg, beginning in the vicinity of the knee and encroaching Scarpa's triangle. The dimensions of the tumor were, fifteen inches in length and twelve inches in breadth. The increase in size had been rapid. A chain of glands could readily be detected in the inguinal region At this time the thermometer revealed no difference of temperature between the limbs. I thrust into the tumor an inspirating needle of large calibre, in different directions, from which neither blood nor pus issued; consequently I was unable to make an accurate diagnosis. The query then presented itself: What is the pathology of the case? From the evidence I had obtained, I was compelled to denominate it a soft sarcoma, as the non-appearing of blood or pus contra-indi-

cated the presence of an encysted abscess, or an aneurism. My opinion was concurred in by several eminent professional brethren. In view of the man's deplorable condition, I proffered him an amputation at the hip-joint as the only source of hope for relief and recovery. He accepted gladly the proposition, notwithstanding I endeavored to impress upon his mind the great dangers attending such a procedure. I sent him at once to the Church Home Infirmary, for preparatory treatment, as his vitality was at a low ebb.

May 24th, at 2 P.M., I had him placed under the influence of chloroform, for the purpose of making an extensive incision through the tumor, to verify or set aside my diagnosis, prior to opera ting. The contents of the tumor was coagulum. The circulation in the diseased limb had nearly ceased, lowering its temperature, and gangrene seemed imminent, therefore, I proceeded to perform the amputation at the hip-joint, after the manner of Erichsen. Having used Lister's compressor, the amount of hemorrhage was reduced to a minimum. Upon the removal of the limb, I dissected from the flaps some heterologous tissue, which unfortunately was not subjected to the microscope. After the ligation of the blood vessels, the edges of the wound were brought together and secured by silk sutures. I found the nævus needle more convenient than the ordinary surgeon's needle. Reaction from surgical shock occurred in due time, under the careful use of stimulants. No secondary hemorrhage. At my leisure I examined the tumor, which proved to be a diffused aneurism of the femoral artery.

May 25th, rested well during the previous night under the influence of an anodyne; pulse 134, temperature 100.5.

May 26th. Pulse 120, temperature 101.2.
May 27th. Pulse 106, temperature 99.2.
May 28th. Pulse 110, temperature 98.6.
May 29th. Pulse 120, temperature 101.6.
May 30th. Pulse 128, temperature 102.
May 31st. Pulse 120, temperature 101.8.

From the last mentioned date till his dismissal from the Infirmary his improvement was continuous. The treatment was: an anodyne of opium or belladonna every night, to secure rest; ten drops of the tincture of digitalis, to calm the tumultuous action of his heart, alternated with quinine and iron every two hours, as a general tonic, and an enema of soap-suds when required. The diet was meat essences, bread, milk and soft boiled eggs; no stimulants were used after reaction occurred. The stump, as well as the patient, was kept scrupulously clean; at no time was there any unpleasant odor from the wound.

June 14th. I discharged him from the Infirmary, well. Since that time, he has engaged in the fruit-packing business, and is enjoying excellent health.

Baltimore, October 7th, 1880.

Hospital Reports.

BELLEVUE HOSPITAL, N. Y.

CLINIC BY WILLIAM THOMPSON, M.D.,

Professor of Materia Medica and Therapeutics in the University of the City of New York.

GENTLEMEN:—The cases that we bring before you to-day, as well as those we brought before you last week, illustrate symptoms due to a single disease, but which in the olden times, before Bright's discoveries, were supposed to be due to several different diseases. Should you ever be reading the diaries of the days when they used to keep diaries, as in the times of Charles II and William III, before there were newspapers, you will find descriptions of the illness of a number of great people, who were supposed to have had from ten to fifteen diseases. We can now say, with little question, that William III died of Bright's disease of the kidneys; but he had symptoms which were ascribed to grief, on account of the death of his wife. But it is very doubtful, indeed, whether his affections were very much lacerated by that loss. I have no question that his complaints were really due to Bright's disease. His court physician told him that he would not have his legs for all his kingdom, because he had dropsy; that the dropsy had a way of getting into the brain. Now, that shows us what kind of dropsy it was; that his majesty certainly had very bad kidneys. But that was not known at that time. It is put down in the diary, one day, that he had very severe difficulty in breathing; another time, that his stomach had commenced to be affected; at other times he became very forgetful of everything that happened, seemed to be entirely wrapped up in his own cogitations; but, in fact, I suppose he had some uræmic lethargy, coma, and so on. It is quite amusing to read such accounts, taken down with such minuteness, without any idea of making a medical history. But now-a-days we have a key which shows us that the cause of many symptoms which were then supposed to be due to many diseases is Bright's disease of the kidneys, which gives rise to poisoning of the blood and the various troubles consequent thereon. There is not a disease that Bright's disease will not simulate in some degree, in different patients.

Now, what symptoms are likely to manifest themselves in different patients? The symptoms will probably be influenced by a family tendency. Patients who come from a dyspeptic stock will probably complain of gastritis the first thing, on being affected by Bright's disease; patients, on the other hand, of a phthisical stock, will first

present some pulmonary difficulty; others have a tendency to nervous complaints, and will give some cerebral trouble as the first symptom, and so on. In other cases, there is an early tendency to dropsy. Now, these are facts which have led us to look to Bright's disease a good deal more than to almost any other disease, for the cause of obscure affections; and I cannot, therefore, be too emphatic in telling you that, as a routine thing, you ought to examine the water in every case, no matter how far the complaint may seem to point from renal disease, for the diagnosis will have very much to do with the prognosis and treatment. In the patients before us, whom I have not seen before, we shall probably find nothing in their story that would give us scarcely the slightest idea of Bright's disease.

How long have you been sick? (No. 1.) "About four months." Gentlemen, do you notice anything particular about his countenance? "He has a stare." Yes, he stares. That is pathognomonic. There is no disease that does that but Bright's disease, with the exception of a very few cases of chlorotic anæmia; but I doubt whether even they are not cases of renal disease. But there is that stare. In passing through the hospital, you can see certain patients looking around with that expression of the eye. Now, what makes the man stare? Is it because he opens his eyes pretty wide in looking at you? You would notice it whether or not he were looking at you. No, it is not because the eyes are opened widely, nor are the pupils par ticularly dilated, and yet he looks as if he were staring. Not only is this symptom peculiar to this disease, but it is peculiar also to a certain stage of the disease. There is a great deal of the elements of prognosis in that stare, for the reason that there is complete dullness of the iris. It does not contract readily, nor does it dilate readily. It is becoming paralyzed, and the expression of the eye depends upon the iris. The rapidity with which the iris answers to nervous impulses from within is that which renders one eye bright and another dull. And it is a pretty good indication, therefore, of the degree of cerebral activity that is going on within; because, if a man is thinking rapidly, particularly if he is using the highest part of his mind, the will, his eye is bright.

The almost inconceivably small fibres of the iris are thrown into tremors by the action of the brain, and give expression to the eye. But let a man be sleepy, the eye grows dull. So the condition of toxæmia or blood poisoning, in Bright's disease, is one which tends to coma, commencing with paralysis of the sensory impressions, and afterwards of the motor and the sympathetic notably. Now, that never occurs until you have commencing poisoning of the nervous system; and hence you may have, before long, those results of toxæmia or blood poisoning, in the way of paralysis.

Then, you say, your complaint began about four months ago; what was the trouble? "A little dimness." Were you ever sick before that? "I had had inflammatory rheumatism, off and on, for five years." Where did it take you first? "In the feet. About a year afterwards it came in my arms." Then you never had the rheumatism in the knee, nor elsewhere than in the arms and feet? "No, sir." Had you any other trouble? "About five years ago, when I had rheumatism in the feet, had pleurisy." How long did the attack of pleurisy continue? "About three or four weeks." Did you have any trouble with the stomach at all? "No, sir." Never threw up your food? Did you have any headache? "Yes, sir." When did you take the headache? "For six or eight weeks." You say you stopped work; why? "On account of rheumatism." Have you had diarrhœa or dysentery? "No, sir." And you have no swelling about the body, any place.

Here, gentlemen, we have a case that began with rheumatism. Now, Doctor, just feel his arteries and pulse; we will find that his condition, instead of being a recent one, is a very old one. That is a typical case of corkscrew artery. It is very hard, very rigid; it is a very weak pulse, and incompressible. Doctor, do you think the pulse is weak? "I do." How can you tell that it is a weak pulse? "By the heart." Did you try the heart? "No, sir." Then you guessed at it.

Now, here is another case, in which we have probably a different class of symptoms. How were you first taken sick? "With pains in the feet." How long did you have pains in the feet? "Seven years." You say it is all through you now; but it began in your feet. You did not have trouble all over the joints at the same time. It would be a month or so between the attacks in the feet, and legs, and knees. What else happened? You lost your strength; your strength seemed to go away altogether. Did you have any other trouble besides loss of strength, and pain in your feet and all your joints? "No, sir." Have you been sick at your stomach at all? "Yes, sir. When the pains came on me, I felt sick at the stomach. For four or five days would have no appetite." Have you had any trouble in breathing. "No, sir. Have had some cough." Have you had headache? "Yes, sir. It is very bad now." You say you have no trouble with the eyes, except that your sight is not so strong as it used to be; it got dim when you tried to read. Is it dim one day and better the next, or is it dim most of the time? "It is dim most of the time." For how long a time have you had headache? "For twelve months." When you had headache did you ever get sick at the stomach? "Yes, sir. Would throw up." Was it only after eating? or did you throw up at times when you had not eaten? "Yes, when I had not eaten anything at all."

Observe this patient's ear, gentlemen; come down and look at it. There you will see something which will tell you at once what diagnosis to make, and consequently, what treatment to pursue. It is a very beautiful example of the gravel-like deposit in this locality which occurs in many cases of Bright's disease.

Now, here are two cases, whose history differs altogether from the history given by the patients last week. They came with a story of rheumatism, and unless you had some hint as to their kidney trouble, you would probably treat them simply for rheumatism. You have felt their arteries, and find that they are just like cords or

little wires under the skin. These are both cases of gouty disease of the kidney; and if the gout had not involved the kidney, they might have gone on with scarcely any real shortening of life or visible shortening of life, by such a moderate amount of gout as they have had. It is very often the case that gout, after affecting the bones, affects the viscera; and on the whole, I do not like to have a case that has been an articular gout to change and give the joints no further trouble. for sooner or later we are likely to have a great deal of mischief with some viscera of the body.

Now, in the ears of this female patient you observe that there is a deposit of that gouty material, forming what are called beads, and they always mean just that and nothing else. No other disease will do that, and hence such a symptom is of itself of very great value in diagnosis. It tells you that the obscure symptoms of the patient, if not due to renal disease, are due to masked gout. I have one patient now, who has no other symptom at all distinctive of gout, except one small bead in the ear, and that is perfect; it is as good a specimen even as this. That patient has a great deal of palpitation of the heart, and is affected very often with a very disagreeable sensation about his head, and sometimes with bronchitis. Now, although he has not yet had a single great toe or joint affected, I have no question that his symptoms, palpitation, dizziness, occasional dyspepsia and bronchitis, are gouty; and I find that giving him gout medicines relieves his bronchitis very quickly, whereas, if I should give him, instead of that, the ordinary bronchial remedies, they would not do any good.

Now for the lessons that these two cases teach us. In the first place, they teach us that the first symptoms which the patient complains of have, of themselves, no significance at all. The first thing they complained of is pain, and pain is not a special symptom of Bright's disease. Bright's disease is a most dangerous disease, from the fact that it has no pain usually. When one has a pain, he is very anxious to find out its cause; but he is very apt to overlook even grave conditions, if they do not cause pain. Now, the first thing that affected these patients was pain in the joints, which was due to gout. It began in the lower joints in both of them. Had I seen these patients when their gouty symptoms first began, I should have suspected Bright's disease, and for this reason, that articular inflammation, either of rheumatism or gout, does not affect the general health as such. Take rheumatic patients, those who have had frequent attacks of rheumatism, generally, you will find their complexion of very good color, their skin clear, even too much so, and quite florid; they have not lost flesh. I am speaking now, of course, of those who have not suffered from heart trouble; a great many of them will be quite fleshy. I have been struck with how well many rheumatics look, notwithstanding their severe pain which they suffer. It is so with gout. Most gouty patients, in the beginning, look the very picture of health.

Therefore, a story of rheumatism and a bad look, a look of anæmia and loss of strength, and of panting for breath, and a wasting of the muscles, and all that, indicates something more than either gout or rheumatism. We would suspect that with this articular inflammation there was too much constitutional decline to be accounted for by the pains in the knees, in the ankles, or wherever else it might be. Whenever this disease, gout, has affected the kidneys and commenced to undermine the constitution, it has gone on a good while.

Again, in these cases we had very few symptoms of the disease which we looked for. We asked about their symptoms from the first. and neither of them had gastritis to any great extent; later on they began to vomit, but they did not begin with it. They did not have very severe dyspepsia. Then they did not have very severe pains in their heads, or else they would have told us so. One of them had pleurisy five years ago. and I have no doubt that that pleurisy was connected with this complaint. I will try to find out about that by asking him some questions. He does not give us a very good account of the matter. I think it very likely he had a very slight attack of pleurisy; but it is not improbable that he had a severe one too. It is in the pleurisy that occurs in the course of Bright's disease that the effusion is out of all proportion to the fever and pain; and not uncommonly will the patient come to you short of breath, and you will find he has pleurisy, without ever having been aware of it.

Now, the cerebral symptoms in both of these cases came on very late. and in both were connected with the eyes. They noticed dimness of vision. The headache was not a marked symptom, because they did not mention it until asked about it. This woman, however, complained of headache, and I then asked when it began, and for this reason: headache is so common an affection that, *per se*, it would not mean anything; but not so, if it has begun recently. A person who is not accustomed to have headache at all, and begins with headache some time in life, has it on account of some form of blood poisoning. That is the meaning of a headache coming on in life, without being an inherited nervous headache; it must mean blood poisoning, in the great majority of cases, so great a majority, in fact, that there are very few exceptions, and therefore it is significant.

We asked this patient whether she has always had headache? No; only within the past year. Notice another fact, it was a hemicrania, it was on this side. Now, a headache that occurs on one side only is supposed, by a good many, to be due to nervous trouble; but not so. It is very commonly the case in Bright's disease that the headache occurs on one side. It is not at all uncommon to have hemicrania as a symptom of this disease. Hence we may lay down this rule, that it is not the form of the headache, nor where it is located, that tells you of Bright's disease; it is the fact that the patient had not had headache for a number of years, at least, and then it began to develop; for such a headache is not hereditary; it is not a dyspeptic headache, such as many have, because a dyspeptic headache begins early in life and continues nearly all through life, from sour stomach, for instance. Hereditary headache develops at a certain time in life, rather early, as a rule, like megrim, and continues per-

haps for years and goes off toward the latter part of life. The headache that comes on suddenly, with symptoms of fever, indicates fever coming on, as typhus and typhoid fever. If it comes on periodically, it indicates a malarial element. But if there be no malarial element and no specific fever, and yet a headache comes on, it may be syphilitic. But make up your mind in regard to that from other symptoms. If it can be accounted for in none of these ways, then look carefully to the kidneys. Look carefully whether they are not wrong, for I am pretty sure that more than two-thirds of such headaches are due to toxæmia from renal disease.

One more fact I wish you to bear in mind: that no matter what causes the Bright's disease in the first place, the symptoms are mainly referable to the vascular system. I believe the glands would not suffer so much, if it were not that the vascular system becomes diseased so early in Bright's disease. The arteries become thickened and the capillaries obliterated, and it is from that you have other symptoms set in, interference with the glands and symptoms of uræmia.

There is one thing more to be borne in mind, viz.: when you find arteries of that kind, you will find an enlarged heart; the heart becoming enlarged in order to carry on its extra work. Now, as a result of the enlargement of the heart, you will find that when the patient has any fever, or anything of that kind, there will be a heart murmur; but these heart symptoms, instead of being the origin of the disease, are the result of the disease.

Medical Societies.

BALTIMORE ACADEMY OF MEDICINE.

Meeting held May 18th, 1880. H. P. C. Wilson, M.D., President, in the chair. Eugene F. Cordell, M.D., Reporting Secretary.

Twin Pregnancy, Intra-uterine and Abdominal: the First Twin Born Naturally, the Second Requires Gastrotomy. Death. Post-mortem.

Dr. H. P. C. Wilson reported the history of the operation, and the post-mortem examination, which he said had been made without the consent of the parties, and hence more or less hastily and incompletely. An incision had been made in the median line, extending from a point three inches above umbilicus to one three inches below. On entering the abdominal cavity a tumor was discovered, very similar to the ovarian, but there was no escape of serum, as invariably occurs in ovariotomy. Adhesions were found between the walls of the sac and the abdominal walls on the right and in front; these were, however, very easily broken up, except at one point, where, in endeavoring to separate them, the finger entered the sac. The amniotic fluid gushed out; the patient was turned on her right side, to let this escape. Being again turned on her back, the fœtus could be plainly felt. The sac was now incised, to the extent of the external opening, when the child was found occupying a position with the breech down and head up under the woman's stomach. The head was also more to the front than the breech. With two fingers in the groin, the fœtus was extracted without difficulty, but there was some trouble in resuscitating the child. However, it is now doing well. A double ligature was placed around the cord, which was then divided. The cord was traced up and back to the vicinity of the liver and stomach. The sac was thoroughly cleansed with carbolized water and a small atomizer, a large atomizer being kept going also throughout the entire operation. The sac was stitched to the edges of the external incision, and then the lips of the latter closed. The patient survived about ninety hours.

The post-mortem revealed the following state of affairs: The sac firmly attached to the abdominal wall on the right side, so that it could not be torn or dissected away; above to great omentum, equally firmly; also adherent to spinal column, descending colon and small intestine; three placentas occupied the left half of the pelvis, and were attached to body of uterus above left Fallopian tube, and to left broad ligament; the uterus pushed to the right side of the pelvis and very much enlarged. Although three weeks and five days had elapsed since the birth of the first child, there was no difficulty in introducing the hand into the uterus at the time of the operation. A sound entered its whole length without meeting with resistance; a larger sound, which was then tried, entered likewise, to a depth of thirteen inches, suggesting the idea of a double uterus. The explanation was afterwards very clear; the sac was attached to the left side of the body of the uterus, and sac and placenta acted as a splint, preventing the contraction of the longitudinal fibres. The cord divided in three parts, sending three sets of vessels to each placenta.

The operation was done on Tuesday. There was nothing in her condition to excite alarm until the following Friday, when the temperature was $106\frac{2}{5}$; pulse over 150. The sutures were now removed and the hand passed in along the cord, with a view to removing the placenta if possible, but it was found still firmly attached. A carbolized sponge was introduced into the abdominal cavity and the sac washed out every second day with carbolized water, the same being injected daily into the uterus. There was no fetor at any time.

Dr. W. was not satisfied as to the cause of death, although inclined to the idea of septicæmia. She had very little sick stomach. There was no peritoneal fluid found on the post-mortem examination, nor any evidence of peritonitis.

1. There was no chilliness at any time.
2. No sweating at all.
3. No muttering delirium—only a little wandering on Friday evening, which might have been due to anodynes given.
4. The temperature rose 3° in eight hours. Her mind was clear to the last. Her pulse and temperature had not been high—$102\frac{8}{10}$ one hour before death. At 7 o'clock, Saturday morning, he saw her for the last time, when she bid him good-bye. In fifteen minutes she called to her sister to raise her up, immediately after which she suddenly turned livid; there were slight convulsive movements, and she expired.

Dr. Chew suggested embolism as the cause of death.

Dr. Howard, who had been called in to see this patient, said that he regarded it as an abdominal pregnancy from the first, because coincident developments in a uterus bicornis extending as far as the eighth month is unknown. The fœtal heart was distinctly audible; when this is the case and there is no placental souffle, it affords strong corroborative evidence of extra-uterine pregnancy.

Dr. Goodell's case (reprinted from the *Medical Record* in the April, 1880, number of the *American Journal of Medical Science*), had put him on his guard. Supposing that he had a case of extra-uterine fœtation at the ninth month, Dr. G. arranged for doing laparotomy, but was deterred from it by observing alternate contraction and relaxation of the tumor. Four days later a child passed *per vias naturales*, and Dr. G. afterwards ascertained that in making his diagnosis he had passed his sound four inches in one horn of a uterus bicornis, the ovum having developed in the other.

Cases have been reported of a duplex uterus, with double conception, in which the pregnancy has gone on for several months, but, so far as Dr. H. knew, there is no case in which the gestation advanced eight months. Gastrotomy dates back to 1594, and has often been done since.

It is a question whether the *primary* or *secondary* operation ought to be done; that is to say, while the fœtus is yet living or after it is dead. Parry is opposed to the former, but the cases collected by him preceded Listerism.

Dr. Howard approved of the operation in the present instance.

The great dangers to be apprehended are septicæmia, hemorrhage, and peritonitis. Delay is advocated, on the ground that adhesions may then take place, but in this case strong adhesions already existed.

What was the cause of death? The absence of peritonitis was rendered certain by the post-mortem examination. What other disease, likely to occur, could in so short a time produce a temperature of 106⅘°, and a pulse of 150 odd? Nothing but septicæmia; embolism could not. There was no dyspnœa, or suspicious respiration, to indicate heart-clot.

The patient would have died from hemorrhage almost immediately, if Dr. W. had attempted the removal of the placenta; hence he acted wisely in leaving the placenta intact.

In a case of tubal pregnancy, in which Dr. Thomas removed the fœtus by cutting through the vagina, he nearly lost his patient, from hemorrhage, in an effort to deliver the placenta, and was compelled to desist.

In a similar case reported by Lawson Tait, he states that removing the placenta was undoubtedly the cause of the fatal issue, and this taught him the absolute necessity of leaving the placenta untouched.

Under similar circumstances, Dr. Howard would, like Dr. Wilson, have performed laparotomy.

Dr. Erich said, that, while at the time entirely approving the method adopted by Dr. Wilson, he thought the case had taught him a lesson or two. The placenta in these cases of extra-uterine pregnancy, being implanted in non-contractile tissues, is not liable to become detached, and ought, therefore, to remain as living tissue. It is highly probable that nature would then remove it gradually by means of the absorbents, like any other useless tissue, or else it might continue to exist somewhat like an angioma. This theory would explain what became of the placenta, in cases where it was so firmly adherent that it could not be detached and removed. These cases, like that reported by Dr. Reiche, have generally ended in perfect recovery, without any signs of septicæmia, although the placenta never passed. It is now established that, in the abdominal cavity, a ligature may be applied without producing the death of the distal end of the part enclosed. Reasoning from these premises, he should, had he a case like the one under discussion, ligate the cord close to the placenta, clean out carefully, and close up the wound. Should septicæmia occur, the wound could easily be opened and the cause removed. He thought there was danger of hernia from stitching the membrane to the margins of the abdominal incision—the method adopted in this case—as it had a tendency to keep the peritoneal edges permanently separated. He was inclined to think death was due to septicæmia.

Dr. Howard said Dr. Thomas had cured all six of his cases; he (Thomas) approves of stitching the peritoneal edges together. The best modern authorities advise that, if there are no adhesions between the cyst and abdominal parietes, the walls of the cyst should be stitched to the margin of the incision, so as to protect the peritoneal cavity. But in this case nature had already formed strong adhesions, thus obviating the necessity of stitching the sac to the abdominal walls. And Barnes says that in such a case, when the sac adheres throughout the extent of the opening, as in this instance, the operation is scarcely more serious than opening an abscess.

Dr. Erich said he had given his own individual opinions, not those of authorities. Only a few years ago, gradual evacuation for hematometra, caused by atresia of the cervix, was authoritative; now rapid evacuation (according to Emmet) is the better practice.

Dr. Howard thought closing the abdominal cavity the best way to produce septicæmia.

Dr. H. said he was present at the first meeting of the American Gynæcological Society, held in New York, in September, 1876, when a discussion arose in respect to this matter, between Dr. T. Gaillard Thomas and Dr. Robert Barnes, of London. Dr. T. had reported a case of laparotomy in abdominal pregnancy, done by himself, in which the placenta was left alone, a large glass drainage tube being placed in the lower edge of the incision.

Dr. Thomas maintained that when the placenta is left *in situ*, to be removed by nature's efforts, it follows, as a corollary, that the external wound should be left open, to permit of its escape.

Dr. Barnes took exceptions to this practice, stating that had the wound been permitted to heal by the first intention, there might not have been any decomposition of the placenta. But if

symptoms of septicæmia should arise, the wound should be opened,to admit of external drainage. Dr. Thomas maintained that it was safer for the woman, to leave an opening for the escape of detritus, than to close it; because, when septicæmia occurs, it is an unsafe conclusion to make an opening for the escape of septic fluids. For, after lymph has been thrown out, and the process of repair has progressed to some extent, we are not certain of finding the spot from which the poisonous material is passing into the system; feeling that when the external wound is closed, the closure is to a great extent final.

Dr. B. B. Browne said that there could be scarcely a doubt that septicæmia was the cause of death in this case; the large size and the extensive attachments of the placenta made it evident, at the time of the operation, that this would be the chief danger to be apprehended. Parry has collected twenty-one cases of combined intra- and extra-uterine pregnancy, in about half of which both children were carried to full term, and the one contained within the uterus born in a natural manner. In the case reported by Dr. Starley (New York *Med. Jour*, March, 1873, p. 229), the patient was delivered at full term of the intra-uterine child, and died nine weeks after its birth, no operation for the removal of the extra-uterine child having been performed.

Dr. Uhler inquired whether the urine had been examined; also, why the operation was done at the time it was, when pulse and temperature showed fever. Was there possibly any blood, deep in the abdominal cavity, from separation of some portion of the placenta from the partly contracted uterus?

Dr. Wilson replied that no examination of the urine had been made. He was firmly impressed with the propriety of a primary operation. The patient suffered intense agony before the operation, which was only relieved by large doses of anodynes. It had been his desire to carry her as near to term as possible. It was a great wonder the sac was not ruptured before the operation. He had also had regard for the life of the child.

Dr. F. E. Chatard, Jr., said, even if there had been Bright's disease, it was necessary that something should be done. The abdominal swelling had increased very much after the birth of the first child, causing great oppression and even orthopnœa. There were no after pains after the birth of the first twin, but they were marked during the twenty-four hours following the operation.

Dr. Howard said that Elliott had observed cases of pregnancy with albuminuria, whose urine would gelatinize under heat and nitric acid, with casts of every kind and description, and yet had seen the patients recover and remain with healthy kidneys. Hence it is unsafe to say that all such cases must of necessity die, for often they perfectly recover.

In the case of the wife of a prominent clergyman, who had never carried a child over five months, tube casts were discovered, and the urine contained three-fourths albumen. Dr. Howard advised artificial delivery. The specific gravity of the urine never exceeded 1.010. The casts disappeared entirely after the miscarriage.

He was often at a loss to know how to diagnose Bright's disease, during pregnancy, unless the specific gravity is at the same time very low.

Dr. Wilson said, on two occasions the patient had the symptoms of incipient labor pains, which were relieved by morphia. On two other occasions she had colic pains. After the operation she had pains like those of labor —she called them after pains. At the post-mortem he could not introduce one-half of his hand. She had had three pregnancies previous to this one.

Dr. Erich could not see how closing the abdominal cavity, if it had previously been washed out with carbolic acid, and were perfectly clean, could promote septicæmia, as stated by Dr. Howard. This opinion must rest on the supposed death of the placenta, which he did not think would take place.

Dr. Chisolm knew of a lady who has carried an extra-uterine infant for fifty years.

Dr. Howard alluded to a case continuing fifty-six years, in which three children have been born since the missed labor.

Editorial Department.

Periscope.

Cold as a Cause of Deafness.

Dr. Theodore Griffin, of La Prairie, Ill., says, in a communication on the above subject to the St. Louis *Medical and Surgical Journal*, October 5th, 1880:—

It being a fact that serious results do follow the action of cold, we are led to inquire, firstly, how can the injurious effects of cold upon the ears be prevented? And secondly, how can they be cured after they have been developed?

The first inquiry can only be answered by giving directions as to suitable coverings for the mouth and ears in inclement weather. Those whose ears are sensitive to atmospheric changes should not expose them to currents of cold air. When in the street some covering should be worn, not only over the ears, but over the mouth and nose if the weather is severe. Strict attention to the above directions would save many from much suffering.

The mouth and nose are not sufficiently guarded as gateways to the ears. A majority of the diseases of the ear find their way to that organ by their openings. Cold passes through the mouth and nose and on through the Eustachian tube into the cavity of the middle ear. Too little prominence is given to this fact; every

act of swallowing sends a current of air plump into the cavity of the middle ear. After being out in the cold for some time, the air in the mouth and nostrils becomes cold, and it is frequently quite irritating to the sensitive structures of the middle ear.

A woolen covering of some kind worn over the mouth and nose would warm the inspired air and diminish to a great degree this danger to the ear. As a protection to the external ear I would advise any warm covering, but for obvious reasons would warn you against the use of a plug of cotton or any other plug in the external auditory canal, and let but little wrapping around the throat suffice; use the least quantity compatible with comfort.

The answer to the second query is not less important, but compliance with the intricacy of all the delicate details of treatment of many of the diseases of the ear fall most generally within the province of the specialist. To the physician whose armamentarium is made up with the view of combating these diseases, I would say, do not be discouraged by failures to cure, but be thorough in tracing out the pathological condition of every patient's ear which you may examine. Scrutinize every avenue of approach to the ear, particularly the pharynx, fauces, nasal cavities and Eustachian tube; you must become familiar with the use of the Eustachian catheter, the rhinoscope, and all other now indispensable instruments for the diagnosis and treatment of aural diseases. Ear diseases are generally more or less amenable to treatment, though patience and perseverance are often required, both on the part of the physician and patient, for months of treatment are sometimes necessary to perfect a cure.

The Elastic Ligature in Fistula in Ano.

A. W. Perry, M.D., Professor of Medical Chemistry, University of California, says, in a communication to the San Francisco *Western Lancet*, for October, 1880:—

Although the use of the knife in these diseases must ever remain the most direct and preferable operation, on the part of the surgeon, yet there are many patients who carry these fistulas for years, and undergo the acutest suffering several times each year, from a fear either of the operation itself, or because, from their circumstances, they are unable to remain in bed for a few days after the operation. For this class of cases the elastic ligature is admirably suited; and I only wonder that as long as it has been known it is so little used. I have asked a number of my confreres, and I have not found one who had ever used it. I have operated several times by the elastic ligature, and have always found that it causes no pain, and no detention whatever from the patient's occupation. Solid rubber cord $\frac{1}{8}$ in. in diameter (elastic ligature cord) was used, and was pulled with a force of 4 oz. The cord cuts as far as it will, in about four days, and then must be tightened again. One tightening has usually been enough with me. In one case, the man had suffered with a fistula many years, but always dreaded to have it cut; its external opening was $\frac{3}{4}$ in. from the anus, and the internal opening $1\frac{1}{2}$ in. above. This cut through in six days. The ligature was tightened on the third day. The cut produced by the ligature healed entirely in three weeks.

Another case had an old fistula never operated on. It was an inch from the anus, and entered the rectum two inches above. This was divided by the ligature in seven days, with one tightening on the fourth day. In neither case was there any inconvenience, beyond a slight smarting the first day the ligature was tightened. To perform the operation, a flexible silver probe, with an eye in one end armed with silk, is passed through the fistula into the rectum and out through the anus. By means of a silk, the elastic cord is pulled through, the ends tightened by a pull which would raise four ounces, and they are then tied together close to the skin with silk. It is not well to have too much tension on the ligature, as it causes pain. If the ligature divides the tissues slowly, they will heal up behind it. One important point in the after-treatment (as well as in incised fistula) is to cause soft motions by Freidrichshall and Hunyadi Janos water, or a saline cathartic taken in the morning before breakfast; and immediately after the evacuation an enema of warm water, or infusion of mallow root and linseed. This puts the parts in the very best conditions for healing. For want of such treatment, one often sees the cuts for fistula remain unhealed an indefinite time.

Oxalate of Cerium in the Treatment of Cholera Infantum.

A country practitioner writes to the *Concours Médicale*, on the treatment of infantile cholera by oxalate of cerium. He says, "profiting by a slight epidemic of diarrhœa among children and adults, I administered oxalate of cerium regularly, in doses indicated by my *confrére*, Dr. Poulet, viz., four grains divided into ten powders for children under two years, one to be given every hour; eight grains in ten powders between two and ten years; and fifteen grains similarly divided for adults. *Without any exception*, I have obtained rapid and absolute cessation of the vomiting, and in four cases, complete cure of the diarrhœa. In a child of a month old, already much attenuated by the disease, I renewed, during three days successively, the dose of four grains in ten powders; each time I obtained the cessation of the vomiting, which returned when the medicine was discontinued. Unfortunately, it was impossible for me to arrest the diarrhœa, and the child succumbed; but I am convinced that if I had been called in earlier I could have saved it. I cannot impress too strongly the importance of the cessation of the vomiting, as it permits the employment of the administration of the remedies usual in these cases. I tried to give the oxalate of cerium in a mixture, but I had to abandon it in favor of the powders. In a word, the employment of oxalate of cerium seems to me indicated in infantile cholera, and the cholera nostras of adults at the vomiting period. Its action upon the stomach is incontestable; and if that which it exercises on the intestine is more doubtful, it permits, at least, the recourse to other medicines; the ad-

ministration of which would have been otherwise impossible."

Value of Salts of Ammonia, etc., in Diabetes.

It has been shown by various authors, according to *Berlin. Klin. Wochensch.*, No. 38, 1880, that salts of ammonia are eliminated by the carnivora and herbivora, in the form of urea; and Adamkiewicz has shown that this is the case also in the human subject. On the theoretical ground that salts of ammonia might also diminish the quantity of sugar voided in the urine, the latter investigator proposed to employ them in the treatment of diabetes, and published several cases in which they seemed to have this action. Dr. P. Guttman, physician to the Baraken-Lazareth, Berlin, tried this method of treatment in a diabetic patient, with the following result: During the first five days, in which no medicine was given, the average amount of sugar excreted per day was 231.65 grams; during the succeeding thirty-one days, in which ammoniacal salts were given freely, it was 223.11 grams per day; while during the immediately subsequent period of thirty-one days, in which no medicinal treatment was pursued, it fell to 173.19 grams per day. These figures tend to show that the salts of ammonia not only do not lessen the excretion of sugar, but perhaps even augment it. The same case also was afterwards treated by the Carlsbad water (Mühlbrunnen), and carefully observed for thirty days, with the result that the loss of sugar was not in the least diminished, but rather increased.

Pilocarpine Hypodermically.

Dr. F. J. B. Quinlan, of Dublin, says, in a letter to the *Medical Press and Circular*, Sept. 29th, 1880:—

The properties of the Jaborandi leaf have been experimented on by Gould, Murrell, Ringer, Langley, and others, and used in the form of an infusion or a tincture of definite strengths, it produces copious perspiration, or sometimes salivation. In some instances it causes contraction of the pupil, and temporary interference with vision; or less often vesical symptoms. As to its action on the heart there has been some difference of opinion. There is no doubt, however, that it accelerates the action of the heart, relaxes the vaso-motor system, and lowers the temperature. My experience is that the safest and best method of administering this drug is by the subcutaneous injection of the pilocarpine alkaloid, a plan which usually brings on copious perspiration in a few minutes, and without congestion or any of the other symptoms above described.

For the last four years I have repeatedly used it hypodermically, and the only inconvenience which I have found is that it sometimes causes acute pain in the end of the penis. I would not hesitate to so employ pilocarpine in a case where I desired to cause diaphoresis; the more so as its action (should it become excessive) can be at once checked by the exhibition of a minute dose of atropia, which is its direct therapeutic antagonist.

Menstruation During Pregnancy.

Dr. Levy, in *Arch. f. Gyn.*, xv, p. 361, considers, first, the physiology of menstruation, and gives a review of the literature having reference to menstruation during pregnancy, and then states at length his experience in this matter, derived from the investigation of ten cases. In six of these cases there was disease of the cervix, in one the patient aborted, in another the child died in utero, while a third patient suffered from recent syphilitic disease. In all ten cases, menstruation in general was very irregular, while during pregnancy there was only an occasional loss of blood for 1-1½ hour. Levy holds that what is called menstruation during pregnancy is simply pathological bleeding, and that such changes of the inner surface of the uterus as accompany genuine menstruation would be certain to disturb the course of the pregnancy.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——"The Proper Period for the Performance of Amputation in Cases of Traumatic Injuries," is the subject of a paper by B. A. Watson, M.D., Surgeon to Jersey City Charity and St. Francis' Hospital, N. J., which comes to us in pamphlet form.

——A pamphlet extracted from the Transactions of the Medical Society of the State of Pennsylvania, for 1880, contains a statistical "Enumeration, Classification and Causation of Idiocy," by Dr. Isaac N. Kerlin. The paper shows a large amount of research.

——Dr. L. Duncan Bulkley sends us two pamphlets, one containing an article "On The Management of Infantile Eczema," reprinted from Transactions of the Medical Society of the State of New York, for 1880; the other containing one on the "Use of Sulphur and its Compounds in Diseases of the Skin," reprinted from the *Archives of Dermatology*, for July, 1880.

——We have just received a pamphlet reprinted from the Cincinnati *Medical News*, containing some very sound remarks on "Capital Punishment," made by Dr. R. R. McIlvaine, in the Medico-Legal Society of New York. As a remedy for murder the Doctor proposes, instead of capital punishment, to break up the causes which lead to this crime. These he considers to be: 1st. Absolute necessity. A man's stomach will not reason. As a matter of course, it requires to be satisfied, and hunger has no reasoning capacity. 2d. Injury, either real or supposed. 3d. The love of gain.

BOOK NOTICES.

A Treatise on the Practice of Medicine; for the Use of Students and Practitioners. By Roberts Bartholow, M.A., M.D., LL.D., Professor of Materia Medica and General Therapeutics in the Jefferson Medical College, of Philadelphia; formerly Professor of Theory and Practice of Medicine and Clinical Medicine in the Medical College of Ohio, etc., etc. New York, D. Appleton & Co., 1, 3 and 5 Bond Street. 1880. Cloth, 8vo, pp. 853.

This treatise is intended by the author as a companion volume to his work on "Materia Medica and Therapeutics. In his preface, we are informed that as the latter work embraced those topics of importance to the physician, and omitted matters of extraneous interest, so in the preparation of this volume, it has been his purpose to include the subjects embraced under the title of "Practice of Medicine," omitting those topics of general pathology, etiology, etc., with which the works on practice usually open, and incorporating them in their proper relation with individual diseases. Each disease is therefore discussed under the following heads: Definition; Causes and Symptoms; Course; Duration and Termination; Diagnosis; Prognosis and Treatment; and the whole subject is treated in a concise manner, and with the definiteness of an authority which the author's extensive and varied experience entitles him to. The book appears to be fully up with the times; and is especially valuable as a text-book to students and young practitioners. It is provided with forty-six pathological illustrations.

The Ocean as a Health Resort. A Handbook of Practical Information as to Sea Voyages, for the use of Tourists and Invalids. By William S. Wilson, L.R.C.P. Presley Blakiston, Philadelphia. Cloth, 8vo, pp. 261, with chart. Price $2.00.

The value of sea air in the treatment of a large class of diseases has recently been widely recognized. Long voyages, especially in tropical climates, have been observed to work remarkable alterative effects in various chronic diseases, especially in phthisical and scrofulous subjects. We are glad, therefore, that such a competent hand as that of Mr. Wilson has undertaken to set forth both the advantages and the drawbacks of sea voyages. Most of his work bears especial reference to the voyage from England to Australia. But sea voyages are so much alike that his chapters can be profitably read by all who propose a voyage for health.

His first chapter mentions the diseases in which a sea voyage has been found of benefit. He considers that a health voyage must not be less than a month in length, and that for consumptives the suitable voyages are very few in number. Supposing a sailing vessel to have been chosen, Mr. Wilson explains what preliminary arrangements are necessary. Having started, he describes the life at sea; the management of the health at sea; what occupation and amusements are possible; what objects of interest may claim attention; and the weather an Australian voyager is likely to encounter. To each of these subjects a chapter is devoted, and also one to Australia, its climate and health resorts; one to South Africa and its climate, and one to the meteorology of the ocean.

The author's observations are original and judicious; he speaks from actual experience, and pronounces decidedly in favor of such a voyage in many cases of illness of pulmonary origin or general exhaustion. A chart accompanies the book, showing the Ocean routes, and illustrating the Physical Geography of the Sea.

A Manual of Minor Surgery and Bandaging. By Christopher Heath, F.R.C.S., Surgeon to University College Hospital and Holme Professor of Clinical Surgery in University College, London, etc. Sixth Edition, revised and Enlarged, with 115 illustrations. Philadelphia, Lindsay & Blakiston, 1880. Cloth, small 8vo, pp. 342.

This work is intended as a guide to house surgeons and dressers in hospitals, who may at any hour be called upon to treat such accidents as are daily occurring in large cities. In an introductory chapter the relation of the house surgeon to dressers, to the visiting surgeon and to other members of the hospital staff, and other general matters, are discussed. The remainder of the book is devoted to the treatment of hemorrhage; wounds; retention of urine from various causes; poisoning; minor operations; dressings and bandaging; fractures and dislocations; case taking and post-mortem examination. A number of pharmacopœial formulæ of the London Hospitals and Hospital Diet Tables, together with a complete alphabetical index, are appended. The book will prove of great value to those for whom it has been written.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

QUESTIONS ABOUT VACCINATION.

One might suppose that pretty much all the questions about such a simple matter as vaccination had been settled. Not a bit of it. Apparently none of them has got its quietus. They all seem to have broken out afresh this summer. Let us mention a few of them.

Does the efficacy of humanized lymph diminish by repeated transfer? Dr. Atlee, of Lancaster (*Am. Jour. Med. Science*), denies it positively, after a close personal observation of more than half a century. So do some excellent English authorities. Yet we have not asked a physician who has closely compared the effects on the system of pure bovine with humanized virus, who does not state that the former produces a greater constitutional effect.

Should vaccination be compulsory? Every nation which has tried it answers—Yes. But we are very slow to adopt the compulsory system in the United States. People argue, that if a man wants to run the risk of the smallpox, let him do it. That is his business. As well say, if he wants to set his house afire in a crowded street, let him do it. His neighbors have some interest in both matters.

Should cowpox virus be preferred? It is rapidly being recognized that it should be, quite as much to protect the physician from unfounded charges as to guard the patient against possible contamination with one or another blood poison. Even in conservative England there is progress. At a recent meeting of the House of Commons, Dr. Cameron rose to call attention to the practice of animal vaccination, and moved, "That as cowpock lymph, direct from the calf, commonly known as animal vaccine, is of at least equal value as a prophylactic against smallpox with the ordinary humanized lymph, and as its use affords an absolute guarantee against the propagation of those human diseases occasionally invaccinated with humanized lymph, this House is of the opinion that to meet the objections to vaccination founded on the possible communication of other disease through that operation, a supply of animal vaccine should be provided by the National Vaccine Establishment, for the use of those who prefer it to the ordinary lymph."

Should lymph or crusts be used? The English use fresh lymph—"arm to arm" vaccination—almost always; we succeed just as well with desiccated crusts from human subjects, or the dried lymph from the cow.

How many vesicles should be produced? Here, again, the customs of countries differ. The English surgeons produce three or four, the Americans but one. The evidence is strong that the latter plan is just as prophylactic and far more comfortable to the patient.

How explain the steady continuance of smallpox, in spite of the general prevalence of vaccination? The subject was much discussed last summer, in the Parisian journals. Take the last week in June, for examples: According to the official reports, the average mortality of Paris for the corresponding weeks of the last three years was 23.1 per thousand, whereas the week ending July 1st, 1880, gave a death rate of 25.69.

This represents a total of nine hundred and eighty-one, and of these nearly a twentieth (48) were due to smallpox, which was thus six times more fatal than in the three preceding years, when it only caused $\frac{1}{125}$ of the whole mortality, or seven deaths in a total of eight hundred and eighty-four. These figures proved the prevalence of epidemic smallpox, and others were given, to show that it exhibited an unusual degree of severity at the Laennec Hospital, where there are special wards for the reception of variolous cases. The mortality increased progressively, from 10.27 per cent., or one death in 9.63 cases, in 1876, and July 1st it stood at 19.41 per cent., or, in other words, one death in 5.15 cases. Dr. Bertillon, the Director of the Statistical Department of Paris, attributes the persistence of the epidemic to the neglect of re-vaccination; and he pointed out the immunity which this practice has conferred upon the military. From the 1st of January of the present year, to July 1st, the deaths from typhoid and variola among the civil population of Paris were 1043 and 1519 respectively, but the proportion in the army was very different, two hundred and six soldiers having died of the former, while only three have succumbed to the latter.

This has led sanitary authorities in France to ask for *compulsory re-vaccination* in civil life, as well as compulsory primary vaccination.

When should re-vaccination be performed? Most authorities say at the age of puberty; others, whenever exposure is liable. Certainly age is no bar to it. Last winter we knew of a case over sixty-five years, in which a second vaccination produced a perfect pustule; and M. Toledano recently communicated to the French Société d'Hygiéne, the results obtained by him from nearly five hundred re-vaccinations performed at the Hôtel des Invalides, in which he had achieved 68 per cent. of successes in men from sixty to seventy years old; 84 per cent. of successes in those from seventy to ninety years; and had succeeded perfectly in re-vaccinating a hoary veteran ninety-one years old!

These are by no means all the unsettled questions which might be posed. But these are sufficient to indicate how much room there is yet for the intelligent observer to exercise his power in this field. Needless to say that his results will be of no value if he begins with a strong expectation of proving some assumed position, or even with a desire to find one or the other party in the right. There are large interests involved in the decision of some of these questions; there is much political capital in some of them; and there is even considerable feeling in the public mind about them; all of which considerations go to explain why so much has been said and written on vaccination without deciding what one would think ought long ago to have been settled once for all, and put away on the shelf destined for "fixed facts."

PRIVILEGED COMMUNICATIONS TO PHYSICIANS.

This subject is about to receive in this State the attention it merits. From a circular before us, we learn that about two years ago the Obstetrical Society of Philadelphia had their attention called to the fact that the laws of Pennsylvania failed to recognize as "privileged" any communication made to a physician in his professional capacity, even though the information given was absolutely necessary for the proper treatment of the case. This is not so with the other learned professions; for the law distinctly recognizes the confidential relation between the advocate and his client, and legal custom has forbidden any interference between a penitent and his priest.

The Society failed to see any reason for this discrimination, and asked the College of Physicians of Philadelphia and the Philadelphia County Medical Society to unite with them in endeavoring to procure the passage of a law which would protect the public in its confidential relations with the physician, as it is now protected in its relations with the lawyer and priest. The joint committee was appointed, and on investigation, found that several States had recently enacted laws to meet the difficulty; one had been in force in New York since 1828, having been found (on the authority of the New York Medico-Legal Society) to work satisfac-

torily. Not wishing to take any action affecting the medical profession of the State without formal sanction, the committee forwarded a copy of the proposed law (copy of New York law), in the form of a legislative petition, to all the County Medical Societies in the State, and asked for their approval. From a majority, an official endorsement has been received, as well as the signatures of a large number of the individual members. The matter was finally brought before the State Medical Society, and was unanimously endorsed by that body.

The joint committee having obtained the approval and endorsement of the proposed law by so large a number of the physicians of the State, now feel prepared to present the subject to the Legislature at its coming session.

The proposed law is a copy of the New York law, and reads as follows: "No person duly authorized to practice physic or surgery shall be allowed or compelled to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon."

The committee earnestly beg physicians to assist in carrying out a measure so beneficial to the profession as well as to the public, by using all their personal influence with the members of the Legislature from their districts. Should there be found any strong prejudice against this law, in the minds of any legislator, it is requested to notify the committee through their Secretary, Dr. W. H. H. Githens, Broad and Spruce streets, Philadelphia, in order that an endeavor may be made to answer the objection.

Notes and Comments.

The Relation of Menstruation to Ovulation.

The *Medical Press and Circular* quotes two interesting examples of the intricacy of this problem.

M. Tillaux brought before the Academy of Medicine of Paris, on August 31st, a woman on whom he had performed hysterectomy a year previously, for a cystic tumor. He had removed the greater part of the uterus and the tubes, leaving only the intra-vaginal portion of the cervix and a very small stump of the supra-vaginal portion. Both ovaries were preserved, but there was complete interruption of the connection between them and the trunk of the uterus which was left. Since the operation the woman had menstruated regularly every month; the periods lasted three or four days, but have been less abundant than before the operation. M. Tillaux has ascertained by examination with the speculum during menstruation, that the blood comes from the stump of the uterus and not from the vagina. With regard to the genital functions, the woman declared to M. Tillaux that they were performed better than ever, from all points of view. As a kind of contrast M. Tillaux, last November, removed from a girl, aged twenty-two, both ovaries, which were diseased; since the operation the girl, who is wonderfully well, has menstruated every month exactly. From these cases we must conclude that the physiology of menstruation, in its relation to ovulation, which was considered as a question long settled, requires new researches to account for these contradictory facts.

Bromide of Potash in Vesical Catarrhs.

Dr. Angelo Cianciosi, *Bull. Delle. Sc. Med. di. Bologna*, in his memoir, cites seven cases of vesical catarrh treated with excellent results by bromide of potash. He thinks he can attribute to this remedy a prompt and efficacious action in this affection; and when the depressing action of this salt on the vaso-motor nervous centres and on the cardiac plexus is considered, its influence in congested states is easily understood.

But joined with this it has a special action on the respiratory mucous membrane and on that of the genito-urinary organs; the secretions and excretions of these organs contain this salt as Brome ten minutes after ingestion of the remedy, and continue to show traces of its presence for a period of two weeks thereafter, as has been demonstrated by Namias and Rabuteau.

Since, then, the mucous membrane of the bladder is thus in contact constantly with urine more or less saturated with bromic salts, in proportion to the quantity administered, the therapeutic action of this remedy in abnormal conditions of this membrane cannot be doubted. In the cases treated by Dr. Cianciosi, the patients never suffered from bromic acne, because the dose was never more than three grams, and the salt

was pure, containing no bromate of potash, which is injurious if present in the proportion of one or two per cent. But even if a bromic skin eruption should appear, an arsenical preparation can be given at the same time, or the use of the bromide may be suspended for a few days. Finally, it is sometimes necessary to combat the anæmia, and the symptoms of acute or chronic bromic poisoning which sometimes supervene, with the salts of quinine, strychnine, oxide of zinc or iron.

On the Possibility of Transmission of Tuberculosis Through Milk.

We learn, from the *Gazette Médicale de Paris*, that M. Bouley lately presented a communication to the Academy of Paris from M. Peuch, on this subject.

The author having recognized the existence of tuberculosis in a cow, which, notwithstanding, gave three or four litres of milk a day, fed this milk to two young pigs and as many rabbits. It results, from his observations on these animals, that the milk given pure and without boiling was capable of inducing tuberculosis in the animal to which it was administered. In a new series of experiments he intends to ascertain whether boiling will destroy the contagious properties of such milk.

Prof. Bouley, after giving a summary of this communication, presented to the Academy sections of the lungs, liver, spleen, sub-maxillary glands, etc., of a five months' pig, killed sixty-seven days after inoculation with juice expressed from meat coming from the tuberculous cow mentioned above. This latter experiment was made at Toulouse, by M Toussain, of the Veterinary School. The examination of all these sections show advanced tuberculous lesions.

"I have considered," said M. Bouley, "that these incontestable proofs of the transmissibility of tuberculosis from the cow, by the use of unboiled milk and by inoculation with the juice obtained from uncooked meat, should not remain unknown; particularly as similar experiments have been made in Germany, and with like results, but do not seem to have attracted the attention they merited. The danger is then real, and the public should be warned, particularly when, as at present, raw meat is frequently prescribed in anæmia, etc."

In the abattoirs, a rigorous inspection should be made concerning the existence of phthisis in cows; and it would be prudent to boil milk before using, especially when intended for the alimentation of very young children.

Cooking, which destroys cell life as well as parasites, should render both milk and meat inoffensive; and it is this fact which assures the safety of the army. The meat destined for their use not rarely comes from phthisical animals, but the high temperature used in cooking destroys necessarily every noxious property, as concerns a possibility of contagion.

Extremes of Temperature.

Two remarkable instances of bodily temperature are reported in our foreign exchanges:—

In the *Centralblatt für Chirurgie*, July 24th, Dr. Kosürew reports the case of a powerful muscular Cossack, thirty-two years of age, who, falling from a height, received a severe wound of the scalp, penetrating to the bone. He lived for five days after, his pulse being only 44, and the temperature exhibiting only, on repeated and exact measurements, from 27.2° C. (80.8° Fahr.) to 28.5° C. (83° Fahr.) in the morning, and from 26.5° C. (79°Fahr.) to 29° C. (84.2° Fahr.) in the evening. On examination, the skull was found uninjured; the blood of the sinuses and dura mater was of the color and consistence of tar, and the base of the brain was also gorged with a similar fluid. The medullary substance was of a doughy consistency, and exhibited numerous blood-points wherever sections were made.

In the *British Medical Journal*, September 25th. A hysterical woman in the Adelaide Hospital, Dublin, showed a temperature of 131° Fahr., and this when the most stringent precautions were taken to prevent deception.

Worms in Children.

That convenient resource of old doctors—worms—which serves to explain all sorts of children's ailments, does not meet much favor from Prof. J. Mathews Duncan, the eminent obstetrician. He says, in a recent lecture, I have never seen a case of vulvitis that I could ascribe to worms. And I believe that this is an illustration of the injurious tendency to repeat what has been said before. Because one author of repute says a thing every one repeats it. Every one of you has been taught that worms cause convulsions in children, but were I lecturing on the subject of convulsions I should make the same skeptical remarks on that head. I never saw a case of convulsions that I could reasonably trace to worms, and I never saw a case of worms that caused convulsions.

Effects of Salicylic Acid on the Temperature.

Prof. Deplatz, of Lille, in a paper laid before the Académie de Médecine, arrives at these conclusions:—1. Salicylic acid, administered in sufficient doses to the subjects of fever, always has the effect of temporarily reducing the temperature. 2. This temporary reduction may be maintained and increased by the administration of new doses, and by aid of this agent we are enabled to moderate at will the temperature of the sick. 3. Doses of the acid hitherto considered as poisonous, may be exceeded without danger, patients being able to take for several days in succession eight, ten, or twelve grams. 4. The rectum is the best channel for the introduction of the acid, and each enema should not contain more than two grams. These conclusions are based on five cases of typhoid, one of variola, one of puerperal peritonitis, and several of phthisis. They are also supported by experiments on animals.

Foreign Body in the Rectum.

A curious case is reported in the *Allgemeine Med. Zeitung*, August 31st, by Dr. Walser, of Gratz, Austria:—

A man, three days before his admission to the hospital, had passed the handle of a hammer, twenty-five centimetres in length and two and a half in breadth, into the rectum, in order to arrest a diarrhœa; and while doing so, it slipped from his hand and disappeared. The abdomen was moderately distended and only slightly sensitive; and on making firm pressure over the umbilicus, a hard, movable body could be felt, having its end exactly in the middle of the epigastrium. It could not be followed downward, but seemed to have entered the pelvis. The general state of the patient was satisfactory, but he resisted exploration of the rectum so much that he was put under anæsthetics. Although the body could not be felt in the rectum, by pressure and manipulation of the upper end Dr. Walser was at last able to get hold of it with a lithotomy forceps and slowly remove it.

Nettle Tea in Urticaria.

A correspondent of the *Lancet* describes a severe case of urticaria. He adds:—

The line of treatment adopted by me was—internally, half-drachm doses of solution of acetate of ammonia, with five-minim doses of solution of arsenic, and a few drops of chloric ether, in water, every four hours; the application of compound tincture of benzoin to the parts affected locally, and bran baths twice daily. This having failed to give relief, after consultation with Dr. Murrell, of Westminster Hospital, the patient was given a wineglass of nettle-tea several times daily; a solution of carbolic acid (1 in 1000) locally, and a bath twice daily, consisting of common washing soda and water. After a few days of such treatment the patient improved in every respect, the irritation in soles of feet first disappearing, followed by the loss of swelling in the face, and the spots on the body, which resembled no other skin disease but urticaria.

Kumyss in Severe Diarrhœa.

The history of a number of cases of choleraic diarrhœa in infants, treated by kumyss, is given by Dr. A. M. Campbell, in the *Obstetrical Journal*. In regard to the method of giving it, he says:—

"In administering kumyss, the gas should first be expelled, by pouring the contents of a bottle from one pitcher to another. Begin with small doses, gradually increasing the amount; and when the stomach will bear it, barley-water may be used to quench thirst. Before returning to a full milk diet, it is better, for a few days, to use one of the prepared foods. While I do not claim that kumyss is a panacea for every case of choleraic diarrhœa, I can say we have in it a valuable aid with which to treat this most formidable complaint.

Abortive Treatment of Boils.

Dr. Geo. W. Eastman, of Wisconsin, writes us:

In your issue of the 16th inst., received on October 23d, I notice an article on the "Abortive Treatment of Boils and Carbuncles," by the hypodermic injection of carbolic acid. I can endorse all Dr. O'Neal says of the success of the abortive treatment, having used it with happy results for the last eighteen months. I use the full strength of the acid (in glycerine), and deposit drops in different parts of the base of the tumor.

The Chian Turpentine Treatment of Cancer.

This novelty, to which we have before alluded (REPORTER, Vol. xii, p. 540), has, as usual, not answered the expectations held out by its discoverer. Numerous cases are reported where it did no good whatever. It is a passing fashion, but a very agreeable one to holders of the true (and a good deal of imitation) chian, which went off rapidly at $2.50 per ounce.

Correspondence.

Chloral Hydrate in the Treatment of a Case of Poisoning by an Unknown Quantity of Strychnia. Recovery.

Ed. Med. and Surg. Reporter:—

On the 22d inst., about 11 P.M., I was called to visit a woman of doubtful virtue, supposed to have taken poison with suicidal intent.

I arrived at the house about forty-five minutes after the ingestion of the supposed poison; found the patient a tall, large-boned, not very muscular woman, thirty-three years of age, sitting on a lounge, very restless, hands cold, pulse weak and accelerated, respiration hurried, pupils somewhat contracted. She was reticent when questioned as to having swallowed poison, but was willing to take remedies.

As there was no certainty as to what poison, if any, had been ingested, I at once administered to her about twenty grains of pulv. ipecac. in water, as an emetic. The dose had just been swallowed, when her whole muscular system was convulsed with a tremor or shudder, very characteristic of strychnia poison, and slight emprosthotonos, her neck coming in contact with my head as I sat in front of her. I immediately administered to her, dissolved in about two ounces of water, what I took to be, without weighing, twenty-five grains of chloral hydrate, manufactured by E. Schering, of Berlin.

The entire dose had not reached the stomach when she had a second emprosthotonotic spasm, that threw her off the lounge, and a portion of the chloral regurgitated, which she spat out on the floor, but there was no emesis now nor at any time.

I now had her placed on the lounge, on her back, and two men directed to hold her there, where she had a number, perhaps twenty or thirty, of those emprosthotonotic convulsions, the most violent of which threw her against the foot of the lounge when those directed to hold her were off their guard at the time of attack.

There remained great restlessness between the convulsive seizures, but I could not discover that there was loss of consciousness at any time.

Ten minutes after the first, I administered a second twenty-five grain dose of chloral. There appeared about this time great irritability of the bladder, for which she had to be assisted to the night vessel every fifteen to twenty minutes for the next hour, and less frequently for the next twenty-four hours.

The only perceptible change in the next fifteen minutes was that the interval between convulsions was occasionally greater, when it would sometimes be terminated by a more violent surge forward than was the emprosthotonotic attack just preceding. I now, fifteen minutes after the second, gave a third twenty-five grain dose of chloral. Twenty minutes after the third dose was administered and forty-five minutes after the first, general muscular tremors had taken the place of the emprosthotonos to a great extent, the latter not so violent as heretofore. I now administered a fourth twenty-five grain dose of chloral, and in a few minutes the patient became quiet and apparently asleep, though occasionally a general muscular tremor would occur, when she would open her eyes for an instant. I now left the patient, and returned at 4 A.M. on the 23d, when I found that she had rested an hour, then was aroused by an emprosthotonotic convulsion, though not so violent as heretofore, and since, during a period of more than two hours, she had had four or five such.

About three hours after the fourth I gave the patient a fifth (twenty-five grain) and last dose of chloral, and left, to return at 9 A.M., when I learned that she had fallen asleep a short time after I left and slept for an hour and a half. Since there had been no violent tetanic seizures, but frequent general muscular tremors, which recurred for two or three days, gradually growing less in violence and frequency. Owing to the soreness of the muscles and irregular contraction thereof, the patient could neither stand nor walk without assistance for twenty-four hours. I now learned that she was color blind. All objects appeared to her a yellowish brown color, and it was not until the 25th that color sight returned.

She was now more communicative, and having given up for the present the idea of taking her life, gave me a vial containing strychnia in large crystals, from which she said some time during the day, on the 22d, she had taken, as near as she could judge, one-third of the quantity it then held, concealed it about her person until the aforesaid occasion, when she swallowed it. I carefully weighed the remaining contents of the vial, and there were seven grains and a small fraction of a grain.

There were no remedies administered save those mentioned. The inference is, from the severity of the symptoms and their continuance notwithstanding the administration of large doses of chloral, that the quantity of strychnia ingested was sufficient for a lethal dose; and as it was only after the administration of frequently repeated large doses of chloral that the most alarming toxic symptoms gave way, that a fatal termination of the case was aborted by the antidotal power of chloral to strychnia.

Wm. G. Wilson, M.D.

Shelbyville, Ill., October 27th, 1880.

Report of a Case of Typhlitis, Terminating Favorably.

Ed. Med. and Surg. Reporter:—

Mrs. Wilhelmina A., aged thirty-nine, has been married twice, and is the mother of eleven children; was born in Germany.

On the evening of May 14th, 1880, her husband came to me stating she complained of fullness of the chest and difficulty of breathing, for which, supposing it was globus hysterica, I prescribed some antispasmodic remedies, but these not relieving her I was summoned to her residence, to see her professionally; found her with considerable fever and occasionally profuse perspiration; some tenderness in the region of the right ovary. Having attended her about two years previously, for puerperal mania, I attributed a great many of the symptoms as presented in

her case as only indicative of highly nervous and excitable temperament, superinduced by debility. Her tongue was red as liver, pulse 100, respirations increased in frequency, bowels regular, appetite poor; slept little. The debility and profuse perspiration increased, notwithstanding a good sustaining diet, in connection with quinine sulphate in tonic doses. During the whole time of the affection the patient was harassed with flatulency and a burning sensation in the stomach and bowels. I saw her daily, and endeavored, if possible, to find out what could be the cause of the symptoms. There was no obvious enlargement of any kind; the bowels moved regularly.

The patient progressed in this unfavorable and unsatisfactory way till July 12th, when I thought I could detect a hardness in the right lumbar region, or, if you please, about three inches to the right of the umbilicus and an inch below a transverse line passing through the umbilicus. The symptoms having improved and the patient wishing to visit relatives a short distance in the country, I thought a change might perhaps benefit her, so I consented to let her go. She remained in the country two weeks, when she returned, very much discouraged and, if anything, weaker. I, however, now was confident that there was a small, hard tumor in the location named, but could not satisfactorily locate it. I therefore concluded to treat symptoms and wait for further developments; but at the suggestion of the husband of the patient, Dr. T. W. Shaw was called in to consult with me in the case. Dr. Shaw, upon examination, was rather reserved in expressing an opinion, but thought it might be connected with the right ovary. I was satisfied that it was not in the right ovary, for the reason it was too high up. I, however, waited for further developments, watching the patient carefully till August 15th, 1880, being nearly satisfied about the character of the tumor, and had made up my mind to aspirate it, to ascertain certainly whether it was an abscess; but about this time the husband suggested Dr. Emmerling to see the patient with me, and I agreed, informing Dr. Emmerling, by note, through husband, to bring his aspirating instruments with him. On introducing the needle there was no pus flowed through it, but at the point of the needle, after being withdrawn, there was about two drops of pus that had a fecal odor. This determined in my mind that it was an abscess formed from typhlitis, and Dr. Emmerling concurred in my opinion. A warm poultice of flaxseed was applied over the abdomen, and August 16th, through an opening made by the needle, pus ran freely, which had a highly fecal odor. This continued discharging till August 25th, when at least a quart of pus had run out. The pus now lost its fecal odor. About this time I introduced a drainage tube, through which was injected a weak solution of carbolic acid. I feared my patient would die of exhaustion, but she has rallied nicely and is convalescing. Very little pus is being discharged through the gum drainage tube, and the patient bids fair to recover.

October 1st, 1880. Patient has now about recovered. There are two points of interest in this case: The one is her recovery the other is the length of time the abscess was in developing.

J. M. Batten, M.D.

Pittsburg, Pa.

A Case of Strychnia Poisoning—Post-mortem Examination.

Ed. Med. and Surg. Reporter:—

On the night of September 22d, last, I was sent for to assist the Coroner in a case where a young lady had just died in a very sudden and mysterious manner, and in convulsions. Two hours after death I found the body lying in the exact burial position, except slight opisthotonos. Cyanosis and rigor mortis well marked. The tongue protruded from the mouth, and all the muscles seemed to be as rigidly contracted as if they were frozen; not a point in the body could be bent without apparently breaking something. The masseter and muscles of the back and extensors of the legs appeared to be mostly affected during the spasms, and also the larynx, from the testimony of the witnesses. The head, hands and feet were cold, but grew warmer the nearer approach was made to the body. The autopsy, made three hours after death, showed the blood to be reddish and perfectly fluid. The lungs collapsed, mottled and injected. The heart empty on the left side and as rigidly contracted as if frozen. The spleen was congested until it was as thick as wide. The liver was congested. The small intestines injected in places, which gave them a spotted appearance. The bladder contained about eight ounces of urine and was tightly contracted on it. The left ovary was dropsical.

She had at first clonic spasms, but they soon became tonic, and she died in one of them, about thirty minutes from the commencement of them.

The coroner's jury returned a verdict of death from a dose of strychnine, administered by her own hand. About five grains of strychnine was found among her things afterward, in a package labeled strychnine by the druggist. It is impossible to find out how much she took, for she had been poisoning rats, etc.

J. C. Alverson, M.D.

Arbela, Mo., October 5th, 1880.

Milk Sickness or Trembles.

Ed. Med. and Surg. Reporter:—

A cow affected with milk sickness will communicate the disease, through her milk, to her calf; the calf dying, will give the disease to hogs eating the dead calf; dogs eating the dead hogs will die of the disease; and buzzards eating the dead dogs will die of the disease. It is a disease that reproduces the cause in the animals affected. This would be rather against the theory of a mineral poison.

If I am not mistaken, I have seen cases reported, occurring in cattle kept up in cleared ground, thought to be produced by very impure water drainage from the barnyard. I have thought for years the microscope would reveal

the true cause of the disease, if ever discovered. I see that Dr. Gardiner, of Bedford, Indiana, has given a very interesting report of some cases he has seen. Some thirty years ago, or more, I was told by a neighbor that he had known Indians to eat the flesh of cattle dying of the disease, without being hurt by it. They cut up the flesh and dried it thoroughly by heat. It was cut in small pieces, and when dry would not be more than three inches square, with a hole through it, made by the stick on which it was dried. The heat of the fire would destroy all bacteria or other microscopic living growths.

E. T.

News and Miscellany.

The International Otological Congress.

The session of this body was held last month, at Milan. It was well attended, and a number of communications were made, of which we find the following mentioned as prominent by foreign journals:—

M. Politzer described an acute inflammation of the labyrinth (labyrinthritis), independent of meningitis, and cites, in support of this theory, a number of cases. Both his preparations and those of M. Vollipin, illustrating the osseous parts of the internal ear, and the methods of rapidly operating upon the labyrinth, and of making coarse and microscopic preparations, attracted great attention.

A discussion on the antiseptic treatment of inflammatory affections of the auditory canal was opened by M. Loewenberg, who has always found microbia, for example, in the discharge from furunculi from the ear; and who is Pasteurian and Listerian in his views on the genesis and treatment of the affection. He has employed, with good effect, the boracic acid or carbolic acid treatment. Nearly all the Italian aurists present concurred in this view, and had employed simple substances in powder or solution. Novaro, of Turin, favored weak chloride of zinc lotions.

M. Moos endeavored to raise the same question concerning the deafness or defects of hearing of railway officials, as has been advantageously raised concerning their color-blindness and defects of vision. He affirmed, after statistical examination of a great number of stokers and railway engineers, of which he gave numerical details, that these *employés* are more subject than others to certain affections of the ear, and to such an extent that the safety of travelers is endangered by it. He concluded his paper by a recommendation that all such railroad servants should be examined as to their hearing, prior to engagement, and subsequently periodically examined. This resolution was formally adopted by the congress, in the form of an expression of a wish addressed to the various Governments.

Boracic acid again cropped up as a remedy in M. Ménière's paper on the treatment of chronic discharge from the ear, which very warmly recommended its employment as the remedy.

Professor Politzer read the results of a study of paracousia by the aid of a powerful diapason. Paracousia is the name given to that form of deafness in which the patient hears more distinctly in a noise—as when sitting in a railway train, or in any other sonorous medium which powerfully impresses the hearing. Politzer, by placing this strong diapason on the cranium of his patients, finds that they hear much better, no doubt, because the vibrations of the diapason succeed, under these circumstances, in conquering the chain of ossicles, which is always very considerable in cases of paracousia.

The next session will be held in 1884, at Basle.

Milan has been a "head centre" for international medical congresses, this summer, no less than five having been held there.

The Louisiana Lepers.

Dr. Joseph Jones, President of the Louisiana State Board of Health, recently visited and reported upon the leprosy which is found in that State. We have before us a letter correcting some hasty statements made by Dr. Jones. The writer, Dr. Wm. F. Harang, of Lafourche, says:—

I see that the Doctor has been led into a most grievous mistake when he states that the number of cases have materially decreased within late years.

In 1869 four or five lepers were known throughout the parish, whereas at the present day over thirty well defined cases could be cited; a very rapid increase. Moreover, so great is the fear and abhorrence of the inhabitants for these unfortunate victims that they are shunned as so many venomous serpents. One, notably has succeeded in raising a large crop of rice, but now that the harvesting time has arrived he finds it impossible to procure assistance, for either love or money. His son, by the by, is in a frightful condition, brought on by leprosy.

Dr. Jones visited only the more mild cases, his investigations not extending far enough below. The sooner these unfortunate victims are dealt with the better it will be for the community in which they reside. All measures resorted to can be executed without the least danger of personal violence. A more quiet and harmless people never trod the face of the earth. Their rusty firelocks are never brought to bear, but upon the little harmless creatures of the feathered tribe.

Dr. Tanner Distanced.

The *Union Médicale*, September 4th, reproduces a paper originally published in 1831, by Dr. Desbarreaux-Bernard, narrating the case of a murderer who died in the prison of Toulouse, in consequence of an abstinence prolonged during sixty-three days, in order to escape public execution. The exactitude of the statements seems beyond doubt, as the man's case excited great attention among the profession of Toulouse during its progress, and the account of it was read by the author at the medical society of that town. At first efforts were made to feed him forcibly, but his violence was so great that these were abandoned, and only ineffectual persuasion was resorted to. He from time to

time took a few drops of water, and on some occasions drank very abundantly of this—the whole quantity which he took during the sixty-three days being approximately calculated at from five to six litres.

The New York Law.

This law, which we gave last week, has been construed to apply to every one practicing the healing art. It places manipulators, magnetic practitioners, and such like, under the necessity of providing themselves with the legitimate authority to practice the healing art, or of advising simply in a non-professional capacity. Of course, a citizen may take the advice of any person he pleases as to a disease from which he is suffering, but the law will not permit a person not legaly qualified to act as his medical attendant, administer or prescribe remedies, or receive fees for such services without liability to fines and penalties.

Items.

—Dr. Emerson's remarks on conjunctivitis from chloral, published in the October 23d number of the REPORTER, were extracted from the *N. Y. Med. Journal*, to which credit should have been given.

—Dr. DaCosta's "Medical Diagnosis," will soon appear in a new and largely rewritten edition; and also, in Berlin, a German translation of it, by Dr. Hugo Engel, of this city, assisted by Dr. Carl Posner, a late assistant of Prof. Rudolph Virchow.

—Dr. Graham, an old physician of Louisville, who is in his ninety-seventh year, has just started for the mountains on his "last hunt." He is the only living fort-born native of Kentucky. When he came into the world his parents were dodging arrows and tomahawks, and his youth was spent with a rifle in his hand. He says that he cannot die in peace until he shall once more have eaten venison of his own killing and cooking.

Personal.

—MM. Guerin, the surgeon, and Pasteur, the investigator of germs, got so excited over a scientific discussion at the Academy of Medicine, last month, that a formal challenge to settle the matter over swords was sent and accepted; but the seconds succeeded in preventing these two distinguished men thus making fools of themselves.

—The celebrated Russian Surgeon, Nicholas Pirogoff, celebrated, on October 2d, the semi-centennial anniversary of his admission to the doctorate. He is not only a great surgeon, but an eminent philanthropist.

—The eminent chemist, Cavendish, was remarkably reticent and shy. When about to die he rang his bell, and said to the valet who answered the summons, "I feel very ill, and am going to die. Come again in half an hour." The servant, with pardonable anxiety, returned before the time appointed. Cavendish, who was still alive and sensible, observed, with some severity, "You have disturbed my last moments. You will please return at the time I ordered." The man returned and found Cavendish dead.

OBITUARY NOTICE.

Dr. Edouard Seguin, celebrated as a specialist in the treatment of idiocy and allied nervous diseases, died on Thursday, October 28th, at his residence in New York, aged sixty-nine years. He was a native of France, born January 20th, 1812, and received his medical education in Paris, his teachers being Itard and Esquirol. In 1837 he undertook the treatment of an idiot boy, and in about a year after established the first school for idiots, which was the parent establishment of about seventy-five similar institutions now existing in civilized countries. He came to this country after the revolution of 1848, settling first in Ohio After a visit to his native country he settled in New York, and completed his studies as an M.D. in the University College, in 1861. He wrote a number of books and papers on his specialty, and also on Medical Thermometry, which are regarded as standards. At the time of his death Dr. Seguin was President of the American Association of Medical Officers having charge of schools for the education of idiots.

He has been especially prominent, of late years, in the introduction of a system of international uniformity in medical and sanitary statistics.

QUERIES AND REPLIES.

F. G. A. E. 1st. If you have fallen in weight from one hundred and thirty pounds to ninety-five pounds, there must be some cause for it which requires serious attention from your physician. 2d. The careful application of large glass cups to the breasts is said to promote their growth. It is useless to rub with any kind of liniment.

Dr. J. M. P., of Texas. "Nepenthe" is an anodyne mixture prepared by a London firm. The formula has been published, we understand.

Advocate. Insanity is one of the recognized sequela of sunstroke. See the *Half-Yearly Compendium of Medical Science*, July, 1878, pp. 96. A criminal with a history of sunstroke might owe his criminality to that accident.

Opium. We believe there is no alkaloid of opium which is a pure narcotic. They are all or nearly all convulsivants as well.

MARRIAGE.

HILL—LOUGHRIDGE.—At the residence of the bride's father, October 20th, 1880, by the Rev. R. B. Farrer, assisted by the Rev. J. Rossel, T. Benton Hill, M.D., of Ruff's Creek, Pa., and Miss Emma Williamette Loughridge, oldest daughter of J. K. Loughridge, Esq., of Ryerson's Station, Pa.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1237] PHILADELPHIA, NOVEMBER 13, 1880. [Vol. XLIII.—No. 20.

Original Department.

Lecture.

PUERPERAL ECLAMPSIA.

BY WM. H. WATHEN, M.D.,

Prof. of Obstetrics and Gynæcology, in the Kentucky School of Medicine, Louisville, Ky.

(Reported by A. H. Kelch, M.D.)

Gentlemen—The subject I wish to consider this morning is puerperal eclampsia, an epileptiform disease that is met with in pregnant women, in women during parturition and subsequent to labor. The attacks are usually almost identical with those observed in regular epilepsy. Some authors have described quite a variety of eclamptic convulsions—the epileptic, the apoplectic, the hysterical, the hydræmic, the anæmic, and the uræmic.

Now, this far-fetched classification is entirely unnecessary, and confuses the student, giving no tangible idea of the nature and character of the disease, and it ought not to be observed; moreover, hysterical and apoplectic convulsions during labor or pregnancy are just the same as we have at any other time, and should not be styled puerperal apoplectic, nor puerperal hysterical convulsions; nor should we say hydræmic, uræmic or anæmic convulsions; for we do not know if the convulsions result from a condition of hydræmia, uræmia or anæmia. The classification gives us no real idea as to the nature of the disease, because, the etiology is far from being definitely settled.

Whether eclampsia results from a hydræmic or anæmic condition of the brain, or whether it is due to uræmic poisoning of the blood, is not yet known; and therefore, the proper expression is "epileptiform puerperal convulsions." This includes all the varieties of convulsions where they are to be considered puerperal at all.

Unfortunately, we are at a loss to know what is the exact cause of puerperal convulsions, and for that reason our treatment is, to a great extent, empirical, and cannot be directed to the removal of the cause. Hence, we adopt a plan of treatment based upon the results of experience.

Lever, in 1843, demonstrated the fact that in most patients with puerperal eclampsia the urine is albuminous, and this was considered a satisfactory explanation of the cause of puerperal convulsions, and was generally accepted throughout the country for a number of years; but finally it was discovered that this theory would not explain the facts in connection with this disease. It was found, in many instances, when the urine was largely albuminous no puerperal convulsions resulted. It was seen in many instances, too, that there was no albumen in the urine previous to the development of the convulsions, nor subsequently; that they appeared with just as much force and with as dangerous results as though the albumen were in the urine.

It was not supposed, of course, that the albumen in the urine caused the convulsions; but simply that it was the evidence of a disease in the kidneys that prevented the elimination from the system of the poisonous substance known as urea or uric acid, which, when transformed into the carbonate of ammonia, caused the convulsions. This, I say, was generally believed, and experiments were instituted to prove it; but no

satisfactory proof that urea is converted into the carbonate of ammonia has ever been brought forth, and it is now generally conceded that such transformation is, to say the least, doubtful.

Then another theory advanced is embodied in the idea that these convulsions are the result of cerebro or cerebro-spinal anæmia, and that this anæmic condition results from the hydræmic condition of the blood; that there is an excessive amount of the watery elements in the blood, and that with this increased vascularity there is hypertrophy of the heart during pregnancy; these combined cause such pressure upon the capillaries of the brain as to result in effusion of serum into the tissues, secondarily causing this anæmic condition of the brain. This theory is about as plausible as any that has been offered, but it will not explain away all the difficulties in connection with the production of puerperal convulsions, and we are now really at sea with regard to the exact nature of the disease.

You must be familiar with the premonitory symptoms, so that you may be able to prevent an attack, or when fully developed, treat it successfully.

Usually, premonitory symptoms, such as an œdematous condition of the lower, and particulary of the upper extremities and face, headache in the frontal region, disturbances of the cerebrum; in the sight, such as dimness of vision; of specks floating before the eyes; of giddiness, of deafness, etc., are characteristic of a condition that will likely result in puerperal convulsions; and where they are detected, you should be prepared to meet an emergency of this sort, and if possible, to avert it by judicious treatment.

I will now speak of the symptoms when the attack has begun, and then the treatment.

The patient having had premonitory symptoms, or possibly without any of them, is suddenly attacked with a convulsion. The first thing noticed being an involuntary tonic muscular contraction of the face, with the mouth drawn back or to one side, the eyes fixed or rolled back under the lids, exposing only the pearly sclerotic. Then the entire muscular system begins to stiffen. In about thirty seconds this state merges into one of clonic convulsions. The muscles of the face begin to twitch and jerk, as well as those of the body. We find at the beginning of the convulsion the face usually becomes suffused and blackened, from venous congestion. This state of tonic and clonic contraction may last for one or two minutes or for a considerable time, during which there is no consciousness nor is there any sensibility. Finally, as it passes off, consciousness usually begins to return and may be entirely established. There is then no sense of what has transpired during the convulsion. It may not recur at all, or it may recur in a very short while, or in a number of hours, from one to several.

If it continues to recur, you find that in the interval consciousness becomes less and less perfectly restored between the paroxysms, and finally it is entirely abolished and the patient is heedless of her surroundings both during the attack and the interval. We find again, that during the attack there is decided frothing at the mouth and a tetanic condition of the jaws, and unless you have taken the precaution to introduce something between the teeth, the tongue protrudes and becomes lacerated during the paroxysm.

By these characters you will surely be readily able to diagnose a case of puerperal eclampsia, and after you have seen one case, you will always be able to distinguish another, because the same characters prevail in all.

There is a great variety of opinion in regard to the treatment of puerperal eclampsia, and you can see at once why this should be so, because there is no settled opinion in regard to its cause. You know the scientific treatment of disease is to first discover its cause, and then remove that cause, if possible; and where that cannot be determined, we must simply use those remedies which, in the hands of the most experienced physicians, have yielded the most successful results.

In studying the statistics of all the past cases that were available, it was discovered that about thirty-two per cent. of those cases that occurred before and during labor died; and about twenty per cent. of those that occurred subsequently to labor ended fatally; but in the examination of cases that have occurred since the subject has been more thoroughly studied and the treatment more successfully adapted to the case, we find the mortality has very materially lessened, and that it does not exceed fourteen per cent. in scientific hands; and I predict that in a very short time it will not exceed ten per cent. in all cases.

Now, one of the old remedies, one that was for some time discontinued in this country, but which has to some extent been reintroduced and recommended, is venesection as soon as the attack is discovered.

Venesection is unquestionably a decided benefit at the beginning of and during an attack, when the symptoms are violent, and the face and brain much congested. This is demonstrated by clinical experience, for we frequently find the

attack thus cut short, and no recurrence of it for a considerable time.

Granting that the blood is in a hydræmic condition, still there is an excessive vascular tension; and we can readily comprehend how venesection should be immediately productive of happy results, preventing serious lesion of the brain and kidneys by relieving vascular tension; and we can at the same time understand how excessive venesection, or venesection practiced indiscriminately, could be productive of evil results; for when you remove the blood, you remove not only the watery elements, but simultaneously, a proportionate amount of the blood corpuscles that are necessary to the sustenance of the patient; so that, while you relieve that excessively vascular condition, while you remove the immediate danger of structural lesion of the brain and kidneys, you leave the system in a condition that is less favorable to recovery than it would otherwise have been; and it often does not afford permanent relief to the vascular tension, because the blood has the power to absorb from the tissues the watery elements, and thus produce the same amount that existed previous to the venesection. So, when you bleed, do not practice it to excess. Venesection may produce permanent good results, or be of temporary benefit that will enable you to avail yourselves of other treatment, by which you may bring about rapid and favorable results.

When you have controlled the immediate convulsion, then you may resort at once to other treatment to prevent a recurrence, and the best of all remedies is chloroform. It gives the best results, and having put your patient at once under its influence, you can administer it during the convulsion, and during the coma at any time that it is indicated.

There is no necessity for thoroughly anasthetizing your patient, but give enough to control the convulsion, and when it begins to reappear, increase the amount until it is controlled. It must be watched closely and continued for a long time. It is well, when you have once commenced it, that you should administer some remedy that is more pleasing and lasting in its effects, and nothing more fully meets this double indication than full doses of hydrate of chloral.

You may combine large doses of bromide of potassium with it.

Dr. Barker has not experienced the happy results from chloral which have been met with by a great many celebrated authorities upon this subject, and he advises, in its stead, large doses of morphia hypodermically. The chloral may also be administered in this way, giving from four to eight grains in one drachm of water as often as may be indicated.

After the convulsions are brought under control, a brisk cathartic should be given, that will, as soon as possible, clean out the bowels and cause a watery discharge, because in this way you deplete, by relieving the vascular tension without removing the blood elements.

Accepting the theory of the hydræmic condition of the blood, we would naturally expect to have happy results from those remedies that produce profuse diaphoresis. But we find the results have not been in accordance with this theory, and we have, by the use of pilocarpine, administered hypodermically, unfavorable reports, indeed, quite a number of fatal results, and it has been determined that under the use of pilocarpine, where salivation has been produced, the success has been less encouraging than where we have resorted to the other means of treatment I have suggested.

Communications.

CATARRHAL GLAND-FEVER.

BY HUGO ENGEL, A.M., M.D.,
Of Philadelphia,
Fellow of American Academy of Medicine, etc.

I have seen now nine instances of an affection which seems to be not rare, which is not described in any of the systematic works on internal medicine, and in books on surgery only some of its symptoms are alluded to, not as forming a distinct and separate disease, but as manifestations of a syphilitic or a scrofulous dyscrasia. Facts are stubborn and cannot be disputed away; and as only one of the individuals affected with the disease soon to be described was slightly scrofulous, and only one had a doubtful syphilitic taint of the system, it is clear to my mind that the association with either diathesis can only be an accidental one. To illustrate the disease I will give the history of two patients, both typical cases of the complaint they represent.

W. K. I., aged thirty years, of healthy parentage and without the slightest taint of the system; very muscular, with black hair and moustache, brown eyes and a dark complexion in general; of temperate habits and leading a very regular life as one of the chief clerks in a wholesale business; had never needed, as long as he could remember, the services of a physi-

cian. During the night of February 15th he concealed himself in a cellar, from which, for a number of weeks, different articles had been stolen. The cellar was a very damp place, and Mr. I. sat the whole night in one corner of it with his shoes in nearly an inch of water. He had to keep himself almost motionless, the surer to catch the thief, who after all did not make his appearance. The next day Mr. I. felt sick. He had chilly sensations creeping up his back, severe headache, pain in his legs, especially the thighs and in the groins, and aching all over. His temperature was 102°; his skin hot and dry; the pulse 106, full and strong, and the tongue covered with a whitish coat. On further examination I found the whole chain of the superficial and deep inguinal, and a few of the superficial abdominal glands on both sides of the body enlarged and tender; one of the left superficial inguinal glands near the scrotum was swollen the most, and the integument over it inflamed. On the right side were fewer glands, and these affected in a less degree. All the glands continued in this condition for about three weeks, when the one on the left side near the scrotum suppurated, and an opening had to be made with the knife to give an outlet to the pus. During all this period the fever was more or less the same; the temperature in the morning being about 100° and at night 101½°; the patient showed no desire for food; the tongue kept its coating; the urine was highly colored and very acid, but contained no albumen; the bowels moved only sluggishly and the patient lost decidedly in weight.

About five days after the opening of the abscess the glands all commenced to lessen in size; their tenderness, which after the first week of the disease had begun to decrease, disappeared altogether; the fever left; the tongue became clear, and the patient entered upon a slow convalescence, so slow, that to restore his strength more rapidly I was obliged, two months after the beginning of his illness, to send him to Atlantic City, where he rapidly recuperated, and whence he returned two weeks later in good health. It took a month more before all the glands had assumed again their normal shape, and one or two of them are to-day yet a little larger and harder than they should be. About three weeks after the patient's return from the seashore the cavity of the suppurated gland closed finally, and for about a month more some weakness was felt in the lower extremities.

During the first week of his sickness the patient had been very restless at night and occasionally slightly delirious; and only after the fever had totally left did a natural sleep set in. The night before the opening of the abscess the patient was very delirious, and his temperature 103¾. Three times during the course of the disease—in the beginning, the day after the operation, and when convalescence commenced—I examined his blood microscopically, and although it became, as the illness progressed, rather poor in red corpuscles, which lost somewhat their regular outline, at no time could any increase in the number of white globules be noted.

The following gives the description of the disease in a scrofulous person:—

F. N., saloon-keeper, aged forty-six years, with a scrofulous taint of the system, sent for me in March, 1878. I found him in the following condition: Temperature 104⅘°; skin hot and extremely dry; pulse 116, somewhat wiry; tongue dry, brown and fissured; nausea and vomiting; no stool for six days; abdomen swollen, and on the right side all the part from Poupart's ligament to a line drawn transversely across the middle of the abdomen very tender and red. The whole chain of glands—at least seven of the superficial inguinal glands on the right side—was enlarged, hot and tender; two of the superficial abdominal glands on the same side and two of the superficial inguinal glands on the left side were in the same condition, except they did not feel hot to the touch and the integument over them was not changed in color. This state of affairs was complicated by the existence of an irreducible right inguinal hernia, and on account of the swelling and discoloration of the parts and the symptoms present I was at first in doubt whether I had here as complication a strangulated hernia or not. I elicited the following history: Two weeks before I saw the patient he had been working one day in a large refrigerator in the cellar; "his stockings were wet and his feet ice-cold" when he had "finished the job." In the following night he was attacked by a chill, after which fever followed, and since then he had been in about the same condition as our first patient in the first two weeks of his illness, he, too, being flighty at night. Three days before my appearance a decided change for the worse had taken place. The enlargement of the glands was observed by him the next day after the exposure, and within twenty-four hours those on the right side had become so painful that he could not move his right leg. A member of that dubious profession, "homœopathy," had man-

aged to get the patient into the rather dangerous condition above described. I ordered the application of twelve leeches, to be followed by continuous hot fomentations, which were to be sprinkled over each time with lead water, and prescribed fifteen grains of blue mass and a bottle of citrate of magnesium, to be taken three hours later than the first. The patient had, soon after the citrate of magnesium, an enormous stool, and when I saw him the next morning he was very much improved. His tongue was moist and had lost most of its coating; all symptoms of local peritonitis had disappeared, and after Professor S. D. Gross, whom I had called in consultation, had laid open two of the glands, an operation which, on account of the great swelling of the parts and of the existing hernia complication, was no easy one, the case took the same aspect as the one before, with the exception that whenever N. would seem to be convalescing the temperature would suddenly rise again, all the symptoms reappear and another gland suppurate. In this way the case dragged on for fifteen weeks, when, at last, the whole seven of the right superficial inguinal and the two superficial abdominal glands of the same side having suppurated, the patient entered upon his slow though now final convalescence, having wasted to a mere skeleton. About two more months passed before his health was totally reëstablished. The weakness in the legs was in this case, too, the last symptom to disappear.

These two cases are types of the disease. In fact, there are only few complaints which, like the one here in question, run, in every individual attacked by it, a so similar course. To recapitulate: A person previously mostly in perfect health has, after an exposure to cold and damp, chilly sensations, which are followed by increased temperature, fever and a rapid pulse. Digestion is disturbed; the bowels are sluggish; the urine is highly-colored and very acid. From the very beginning of the complaint the patient has pains all over, but especially in and near the inguinal regions; and most of the superficial inguinal and a few of the superficial abdominal glands on both sides of the body are enlarged and painful. One or two of the first named, on either the right or left side, are more inflamed than others, and the integument over them is reddened. All these symptoms continue for about three to five weeks, when one or two of the glands mentioned last suppurate. A day or two later the fever and the digestive disturbances commence to decrease, and then rapidly disappear, leaving the patient in a debilitated condition, from which he only slowly recovers. The weakness in the lower extremities is especially apt to remain a long time. The glands return only very gradually to their normal size, and if the individual affected with this disease has been debilitated before, from any cause whatsoever, or if he be a scrofulous subject, then the illness becomes a much more protracted one, as one after the other of the previously enlarged glands will suppurate. While the glands on both sides are affected, only those on one side are apt to suppurate. No other glands of the body, except those alluded to, are ever attacked in this complaint.*

The disease cannot be mistaken for any other. The fever and the acute beginning, as well as the history of the case, distinguish it from simple scrofulous enlargement and suppuration of glands. The fact of the exposure and the number of glands involved separate it from the bubo of syphilitic or blennorrhoic origin. In lymphadenoma the number of white corpuscles is increased, which is not the case in the disease here described. No other complaint could possibly be taken for the latter.

As regards therapeutics, I must say, in advance, that my experience has taught me that there exists no abortive treatment of any kind. The disease will run its course, and we can only try to prevent suppuration of more than one gland, to hasten absorption of the morbid products of the others, and to accelerate convalescence. The first object we reach best by keeping the patient in bed until we can be reasonably sure that no more glands will suppurate. I apply, from the first day, hot poultices to those glands which seem doomed to break down, and sprinkle over each cataplasm the undiluted liquor plumbi subacetatis, to lessen inflammation of the surrounding tissues; all other glands I paint twice daily with the tincture of iodine, until they have been reduced to their normal size. Absorption is further accelerated by bandaging both legs, from the knees up, and including the abdomen in the bandaging. The patient is put on an easily digestible but nourishing diet; his bowels are kept open by an occasional blue pill, followed by a saline, and internally I employ, throughout the

* I have seen one case, in a lady, where the disease seemed to be a fac simile of the one here described, but the glands in both armpits were affected. The disease ran a very similar course, only that the pain and weakness were referred to the upper extremities. The patient suffered, besides, from small abscesses on different parts of the skin, and got well under a tonic treatment. Here, too, was a history of exposure to cold.

disease, the mineral acids, a favorite prescription of mine being—

R.	Acidi muriatici diluti,	f. ℥ ss
	Tinct. nucis vomicæ,	f. ℥ j
	Aquæ destillatæ,	f. ℥ ivss
	Syrup. rubi idæi, q. s. ad	f. ℥ vj. M.

Sig.—Unciam dimidiam qûaque quartâ horâ.

Is the fever high, I give every second day a single dose of fifteen or twenty grains of quinia in mineral lemonade, the single large dose having a far more favorable influence on the disease than often repeated small doses of the same remedy. The body is twice daily sponged off with tepid water. As soon as the tongue is clear and the fever has subsided, I prescribe the syrup of iodide of iron in twenty-five drop doses three times daily. Abscesses are treated surgically. The moment we attack the glands more vigorously, to hasten either suppuration or absorption, we only prolong the case. In this disease the doctor as well as the patient must have patience. Iodide of potassium and iodoform are useless; mercurial preparations do harm; jaborandi or other diaphoretics debilitate without any benefit, and a tonic treatment with iron, etc., from the beginning, only disturbs digestion more. The best plan to follow is, to tell the patient, on the first day, that if he wants to be able to attend to his business again within six weeks—the shortest possible time—he must stay in bed at least for a month, and then act according to the rules laid down.

The disease undoubtedly belongs to the domain of internal medicine, just as leucocythæmia lymphadenoma, the pest or diphtheria. As in the first the enlarged glands do not constitute the disease, in the second, not the abscesses, and in the last, not the throat affection, so is this a constitutional disease which finds its external expression in enlarged and suppurating glands. And a disease which—almost without warning—will incapacitate an active man (in only such I have seen this complaint) for at least six weeks, for any work, is surely important enough to be put on record and to be thoroughly studied, so that we may perhaps, at some future time, be able to drop the expectant plan of "noli me tangere," and to cut short this more annoying and painful than dangerous complaint.

As mentioned, the disease seems to attack only adult men, which fact can easily be explained by the causing element, and to be self-limiting and to affect a person only once. The name I propose for it, "catarrhal gland fever," is perhaps as good as any one.

A CASE OF ACUTE HYDRARGYSM.

BY J. W. HICKMAN, M.D.,

Of Delta, Pa.

A few months ago a friend of mine, and a graduate in pharmacy, prescribed for himself a few grains of sulphate of quinine in nitro-muriatic acid; he followed this by ten or fifteen grains of calomel. In a few hours he was taken with the most excruciating colicky pains. The evacuations from his bowels were, when I saw him at first, very frequent and copious. He did not vomit nor experience any nausea; his skin was cool and clammy and his temperature 97. The pain was most severe in the region of the umbilicus and was of a twisting, boring character. Upon pressure, the pain was neither aggravated nor relieved. As he lay with his knees drawn up, his countenance wore a peculiarly anxious and frightened expression. He seemed sluggish and did not wish to be disturbed. When questioned he would answer merely in monosyllables. After lasting, with slight remissions, for three or four days, the attack passed gradually off. He was by no means well, however; he complained of indigestion and pain through his bowels. As he expressed it, every bone seemed full of pains, which would keep him awake at night. His appearance was that of one entering upon convalescence from a long spell of sickness. He says in those four days he lost fifteen pounds, and I do not doubt it in the least. In three weeks from the cessation of the first attack he was taken down by a second, differing from the former in not being so severe and in not continuing so long. His pain was now of a dull character, and would cease for an hour or two occasionally.

There was noticeable now, for the first time, a well marked bluish line along the margins of the gums, both upper and lower. This line obtained for several weeks, indeed, was the last evidence of his having been poisoned. His gums were tender and his mouth and throat inflamed. The ptyalism was produced.

This case was interesting to me in many respects. In the first place the diagnosis was by no means easy.

He told me he had taken a large dose of calomel, but that would not cause such serious symptoms. It had not arisen from indigestible food, for, on account of a few days of ill-health, above alluded to, his diet had been the plainest and most digestible. It was not the result of flatus, neither of hardened fæces. It was not a bilious colic for where were the vomiting, febrile

excitement, and the peculiar expression of face attendant upon ailments of this character; in fact, this view was not tenable upon any score. The attack was not inflammatory. Neither was it dependent upon hernia, stricture from any cause, the passage of calculi, nor upon any other usual cause. I began to suspect poison, and questioned him still more closely as to what he had taken. At length I elicited the fact that his dose of calomel had been preceded but a short time by some quinine, and that the quinine had been dissolved by the aid of nitro-muriatic acid. Clearly, now, he was suffering from corrosive sublimate poisoning.

In the second place, though, as before stated, there was tenderness of the gums, a uniform inflammation of the mucous membrane of the mouth and throat, there was neither salivation nor loosening of the teeth. Another point that astonished me was that he became so rapidly and completely emaciated. I have never seen, in any other instance, such complete wasting in so short a time.

Then, again, as to the treatment. During the attack palliative means, with chlorate of potassium, were the agents employed. Upon cessation of pain, each time, I put him upon fifteen grain doses of iodide of potassium, three times per day. This was finally increased to twenty. In less than a month from the last attack he was entirely free from the remotest symptom of the ordeal through which he had passed. After a trip to the seashore he came back restored to his former weight and vigor. I have no further doubt as to the thorough efficiency of iodide of potassium in eliminating mercury from the system.

A REPORT OF SEVENTY-TWO CASES OF DIPHTHERIA.

BY A. O. STROUT, M.D.,
Of Parkersburg, Iowa.

The subject of diphtheria possesses great interest to every practitioner, and any new facts or statistics pertaining to this disease are eagerly sought for. I therefore take the trouble to report these cases, all of which have occurred in my own practice during the last ten months. We have had it, both in the town and country, continuously during that time, and are still having new cases every few days.

By way of preface, lest I shall be misunderstood, I will here state that all the cases reported in this paper are *genuine diphtheria*, and that no case of follicular pharyngitis or other form of sore throat has been taken into consideration.

During this time, however, I have kept a record of over fifty cases of follicular pharyngitis (and many cases I did not record), where the patient would be confined to the bed from three to five days, with a high fever and a very sore throat, characteristic of that disease, but entirely unlike diphtheria to an experienced observer. I have never seen an epidemic of diphtheria that was not accompanied with an epidemic also of this disease; and I am sorry to say, many practitioners call these cases diphtheria; some, perhaps, through ignorance, and many, to enhance their reputation.

In the following table I have classified the patients according to their several ages at the time of the attack:—

From	1	year	of	age	.....	1	case.
"	1	to 2	years	of age	.....	2	cases.
"	2	to 3	"	"	.....	6	"
"	3	to 9	"	"	.....	22	"
"	9	to 12	"	"	.....	13	"
"	12	to 15	"	"	.....	12	"
"	15	to 20	"	"	.....	9	"
"	20	to 30	"	"	.....	4	"
"	30	to 40	"	"	.....	3	"
		Total			.....	72	

Thus it will be seen that the liability to the disease under one year of age is comparatively nothing; while from one to two years of age it is not materially increased; but from two to three years the susceptibility increases quite fast; and from three to fifteen years it reaches its maximum, and again diminishes, until at forty it has nearly ceased again.

The following table shows the mode of death:—

Croup	0
Blood poisoning	17
Uræmia	5
Œdema of the lungs	1
Embolism	1
Total	24

During this epidemic the croupous form has seldom been seen. The greater portion (nearly 71 per cent.) die from blood poisoning.

I have observed that those cases that get well usually commence to improve from about the end of the fifth day of the attack. On the other hand, where they do not recover they get worse very rapidly during the latter part of the fifth day, and die from the sixth to the tenth day, but many more on the sixth and seventh day than later.

When uræmic symptoms supervene it has usually occurred about the fifteenth day, and after the patient had become convalescent, with

the exception of one case, when it came on the twelfth day. I am unable to predetermine what cases will be attacked with this trouble, but have observed that in all thus attacked the membrane came off very slowly. But the amount of the membrane or the constitutional disturbance is no index.

When these uræmic symptoms have arisen, I know of no remedy or combination of remedies that will arrest its progress, as they die in from eighteen to twenty-four hours.

The patient with œdema of the lungs lived thirty-four days from the date of the attack. He had been convalescent over two weeks, and I considered him well, with the exception that he was paralyzed so he could scarcely walk, and could eat and drink only with great difficulty. He seemed to be doing finely till twenty-four hours prior to death.

One died from heart-clot while attempting to arise from the bed.

As will be seen from the table giving modes of death, I have lost twenty-four patients out of the seventy-two, or 33⅓ per cent. But those figures need some explanation, as they include consultations; and in quite a number of the cases I was not called till the patient was virtually dying.

Exclusive of consultations, and where I was called at the commencement of the disease, I find fifty-eight cases recorded, of which ten died, or 17⅓ per cent.; which therefore represents my actual per cent. of loss.

It is a big death rate, but when I look back over these cases I congratulate myself that it is not larger.

I shall not speak of my treatment, any further than to say that my experience has demonstrated that ice water applied to the throat is superior to anything that I have yet tried for an external application.

A table showing age at the time of death:—

Under	2	years	of age	3	cases.
From	2 to 5	years	of age	2	"
"	5 to 9	"	"	4	"
"	9 to 12	"	"	4	"
"	12 to 15	"	"	7	"
"	15 to 20	"	"	3	"
	22	"	"	1	"
				24	

By comparing this with the table showing the number of cases attacked for each year of age, the comparative mortality for each period can be obtained.

Thus, all the cases under twenty-seven years of age died; while out of twenty-eight cases from two to nine years old only six died; and of thirteen from nine to twelve years old, four died. But of twelve cases from twelve to fifteen years old, seven died, or 58⅓ per cent.; and nine cases from fifteen to twenty, lost three cases, or 33⅓ per cent.

Hospital Reports.

BELLEVUE HOSPITAL MEDICAL COLLEGE, N. Y.

CLINIC BY AUSTIN FLINT, M. D.,
Professor of Principles and Practice of Medicine.

Pneumonic Fever treated with the Cold Pack.

GENTLEMEN:—The first case to which I will call your attention this morning is one of pneumonia, or pneumonic fever, and I propose to study this case with some detail, for it possesses in certain points, as it seems to me, a good deal of interest and importance, and I will state in anticipation that the especial point relates to the method of treatment; though it is also a good typical case in which to call attention to the physical signs, and also to some deviations from the rules as regards physical signs.

The treatment adopted in this case is the one that has been recommended of late years, especially abroad, and more particularly by the German writers, namely, treatment by the application of cold; treating the case as we would one of any of the essential fevers, typhus or typhoid, for example; and I want particularly to call your attention to the facts as bearing on the apparent effect of that treatment in this case.

This patient is twenty-one years of age, a cooper by trade, a native of the United States, and was admitted into the hospital on the 29th of September. Nothing of any importance relates to his family history. He has been dissipated in his habits. He has been subject to intermittent fever three months; had chills and fever, as he stated, off and on, for three months, frequently recurring. For a week previous to the 26th of September he had had no recurrence of chills, and felt well, but on the night of the 26th he had a short but severe chill. That is the way pneumonic fever generally commences. No marked premonition, occurring abruptly. The first thing, usually, a well pronounced chill; so that if persons are subject to remittent fever, or if they live in a malarial region, the first idea is that there is a paroxysm of intermittent fever.

This chill occurred on the 26th, three days before his admission into the hospital, which was on the 29th of September. It was followed by vomiting, by fever, and by pain in the left side. I have no doubt it was a sharp, lancinating pain near the nipple, for the acute lancinating pain which is characteristic of pneumonia is generally referred by the patient to the nipple, or that neighborhood, not widely diffused, but to a circumscribed area.

The fever rose and the pain continued, and he soon began to expectorate.

That is the history of the commencement. On

his admission into the hospital he still complained of pain in the left side, of shortness of breath, and he had a cough. He also had pain in the head, and a general feeling of illness, general *malaise*.

Now it is noted here that this attack occurred without any exposure, that he is aware of, to wet or cold. He never had coughed, he says, prior to his present illness. It is rather a traditional custom to consider that pneumonic fever is attributable to the catching of cold. There is very little ground for it furnished by observation. The view that I shall advocate of this disease is that it is a fever; that it is not a primary local inflammatory affection, but it is a fever, and like other essential fevers it has its special cause; specific cause. What that cause is, what is its source, remains to be ascertained.

His expression when he entered was anxious; the face was flushed; the respiration accelerated; he was panting; the pulse was 120; the temperature 104.5°; he expectorated matter which was viscid and tinged with blood, and shortly the expectoration became very distinctly rusty, having the typical character of pneumonic expectoration.

Physical examination revealed at the time of his admission increased vocal fremitus over the lower lobe of the left lung; dullness on percussion; the respiratory sound suppressed. That is rather rare. It was not absolutely suppressed, but nearly so. What little was obtained was of a bronchial character, which was especially brought out when the patient coughed. He had bronchophony, the physical sign which corresponds to bronchial respiration, and with broncophony in this case there was pectoriloquy; that is, speech was transmitted through this solidified lobe. Here, then, we have pectoriloquy as an evidence of solidified lung. You will remember that I stated in my lecture, the other day, that you can always tell by associated signs whether the speech be transmitted through solidified lung or through a cavity. If it be through solidified lung there will be associated with pectoriloquy the characters of broncophony; if through a cavity there will be increased vocal resonance, but not bronchophony.

This record was on the 29th. Nothing special was done on that day, in the way of treatment. On the 30th the temperature in the morning was 104°; it rose at half-past twelve to 105°.

Now the patient was placed in a wet pack. That is, the body, nude, was wrapped in a wet sheet and sprinkled with cold water at short intervals. He remained in this wet pack two hours and fifteen minutes. Let me state, lest I forget it, that in this case the cold pack was very agreeable to the patient. He liked it, and he wanted to go into it when it was not deemed proper he should.

The temperature taken in the axilla—which is understood when not stated otherwise—fell to 103°. He was placed in the pack at eleven o'clock, thirty minutes, A.M., remained in it two hours and fifteen minutes, then was taken out; and at 2.45 P.M. the temperature had fallen to 102°, thus exemplifying the fact that the temperature sometimes falls after removal of the patient from the pack or the bath. At 3.30 P.M. the temperature had risen a little, to 103.5°. The rule adopted in this case was, that when the temperature exceeded 103° the pack should again be resorted to. He was again placed in the pack, and remained in it one and a half hours, from 3.30 to five o'clock. At five o'clock the temperature was about 101.5°. At six o'clock, however, the temperature had risen to 104° again. At 6.30 he was placed in the pack again. Now, this was carrying out fully the antipyretic treatment. This time he remained in the pack one and a quarter hoars. At 7.40 the temperature fell to 102°. Such was the history for the 30th of September.

October 1st, the temperature in the morning was 100.75°. At 12 M. it had risen to 104°. I will say, in passing, that this patient was subject to malarial fever. It may be a question whether we did not have that element involved. At 12.15 the temperature was 104.25°. He was placed in the pack. At 12.45 the temperature had fallen to 103.25°. He remained in the pack one hour. Fifteen minutes after he was taken out of the pack the temperature was 102. At three o'clock the temperature had risen to 102.25°. At six o'clock, however, the temperature had fallen to 101°.

October 2d, in the morning, the temperature was 102.25°. At 9 A.M. it was 103°; at 3 P.M. 102°; at six o'clock, 101.25°.

October 3d, noted that he was delirious during the night; once got out of bed, which is not very uncommon. At 8 A.M. the temperature was 103.25°. As it was above 103°, although only a quarter of a degree, he was placed in the pack, and remained in it an hour and a quarter. The temperature fell to 103° at 8.45; and at 9.15 the temperature had fallen to 100.25°. At 12 M. the temperature had risen to 102.25°. Noted here that the expectoration is still rusty. At 3 P.M. the temperature was 102°; at six, 101.25°.

October 4th, noted that he was delirious during the night. At 8 A.M. the temperature was 99.25°; at 12 M. 98.5°. Subcrepitant râles now heard, which were the return râles, and indicative of resolution. At 3 P.M. the temperature was 97.5°, below the minimum in health, which is not uncommon in patients convalescing from pneumonia.

October 5th, the temperature at 8 A.M. was 97°.

The treatment up to the fifth instant consisted in giving milk and eggs for diet, half an ounce of whisky every two hours, the patient being addicted to its use; carbonate of ammonia, five grains every two hours; morphia, a sufficient amount to relieve pain and secure rest. That constituted all the treatment.

October 5th, noted that the expectoration is now mostly yellowish mucus. In the evening the temperature was 97.25°.

October 6th, the temperature in the morning was 97°, the respiration broncho-vesicular. The carbonate of ammonia was now reduced in amount. The temperature in the morning was 97.5°, and in the evening 97.5°. The urine was normal throughout.

Now, gentlemen, this patient may be pronounced at the present time convalescent, and the treatment, as you see, has consisted principally of this antipyretic measure. The carbonate of

ammonia was given, and whisky was given as a sort of protective measure, as it is generally wise to do when patients are much accustomed to its use.

Here is the patient. Let me call attention to the physical signs as they exist at the present moment. Percussion over the upper lobe of the affected side shows, though not in a marked degree, resonance of high pitch, somewhat tympanitic in quality. The question sometimes arises, whether the flatness or dullness which we find is not due to liquid effusion, or whether it is due to solidification of lung, and it may be due both to effusion and solidification. But as a rule, there is not in pneumonia enough liquid effusion to cause much obscurity of the physical signs. But if there be any liquid effusion, we can generally indicate it by the boundary line between vesiculotympanitic resonance and dullness or flatness. You will notice, that the pneumonia was on the left side in this instance. It is oftener on the right. That is the rule, but the exceptions are many.

We find on percussion here that there is still very marked dullness. At the same time the respiration and the voice show that there has been great progress made toward resolution. There is not much solidification there, although we get this amount of dullness. Let us explain that. With pneumonia we have more or less exudation of lymph, fibrinous exudation, which is not readily removed. It requires considerable time for its removal, and the presence of that layer of lymph gives this marked dullness. Now that layer of fibrine is probably not more than an eighth of an inch thick, possibly a little thicker, possibly a quarter of an inch thick, but I hardly think so thick as that, and yet that layer will give rise to very marked dullness. You can easily test that by experiment. Percuss a healthy chest while nude, and then interpose a thin layer of clothing, and you will see the difference is very marked. This dullness on percussion will remain a while now, while the patient is up and about, and considers himself perfectly well; the dullness will continue for several weeks, because the removal of the fibrine requires some time.

I confess to having had a certain degree of reluctance to adopting the employment of cold in the treatment of pneumonia; and the reason why it has not had any currency in this country (as far as I know it has had very little) is, I suppose, because of that sort of traditional idea which physicians feel, but the people still more so, that cold is antagonistic. It is customary to attribute the disease to an exposure to cold. If a patient were exposed to a cold pack and afterwards taken with pneumonia, I suppose everybody outside of the medical profession, and probably a very considerable proportion of the medical profession, would regard that as sufficient cause for the disease.

Pleurisy.

Case 2.—This patient has pleurisy. He does not look like a very ill person. The division into acute, subacute and chronic pleurisy is to be regarded. There are some incidental points in this case, one in particular, that I wish to call your attention to.

This man is a barber by trade, a native of Canada, 42 years of age, and was admitted on the 4th inst. Nothing important relates to his family history. He has been accustomed to the use of alcoholic liquors. Fifteen years ago he had acute articular rheumatism, and he has had specific disease. Now here is a point. Four years ago this patient had hydroperitoneum; his abdomen became enlarged, his feet œdematous, and he was told that he had cirrhosis of the liver. That was in this hospital, when he was examined carefully by my colleague, Dr. Janeway, and the diagnosis was no doubt correct.

That was four years ago. Since that time he has not drank, except of beer occasionally. Now, gentlemen, here is an instance where disease was a very desirable occurrence. He became alarmed at the idea of having dropsy and cirrhosis of the liver, and he came to the conclusion that it was best to stop the use of liquor, a very sensible conclusion. Anybody would reach that conclusion, but all would not have the perseverance to adhere to a resolution based on that. This patient has adhered to it.

Now, cirrhosis is a permanent lesion. I suppose his liver is cirrhosed to some extent, but the liver, like other important organs of the body, has a superabundance of tissue structure, more than is absolutely needed, and it may be damaged to a certain extent; and if the damage does not go beyond that, and is not progressive, it gives rise to no symptoms. The lungs, the heart, the kidneys, may be damaged; and if the damage is not too great and the disease not progressive, it is not inconsistent with good health. What an important fact that is! And here it is illustrated, because the patient was able to stop the cause, and the disease ceased to progress. His health in all respects has been good. Then make a note of that, gentlemen; you will meet with such cases. A patient will come to you with an enlarged abdomen, legs œdematous, which you remove, perhaps, by internal remedies or by tapping. The cause is cirrhosis of the liver due to alcohol. You say to that patient it is necessary for him to stop entirely taking spirits. If it be necessary for him to take anything in the way of alcoholic liquors, let it be wine or malt liquors. If he will follow your advice, you are warranted in holding out encouragement for permanent fair health.

That was four years ago. The patient now came into the hospital with pleurisy in the left side. The chest was tapped (thoracentesis) and about sixty ounces of clear fluid was taken out. He fully recovered, went out of the hospital well, and was then healthy, able to work from that time up to his present illness. That fact is of value. It was two years ago. It speaks well for thoracentesis. The pleurisy did not recur until the present time. Ten days before his admission this time he caught cold, from, as he says, sitting out of doors. He had a chill the next day, and he had a sharp, shooting pain in the left breast. He also thought he had fever. He had shortness of breathing.

Now, ten days before he entered the hospital he was attacked with pleurisy. He had to take to the bed, and from that fact it is fair to conclude that his pleurisy was of the acute form;

not, perhaps, extremely acute, but we can call it acute. The patient says the pain which he suffered from was not particularly localized or circumscribed, but more or less diffuse, differing from the pain in connection with pneumonia.

When he entered the hospital, physical examination gave the following result: over the lower part of the left side there was absence of vocal fremitus, flatness on percussion, loss of respiratory murmur and of vocal resonance. Above the line of flatness there was increased vocal resonance and broncho-vesicular respiration. The breathing does not seem to be exaggerated on the right side.

Well, we are pretty safe in basing a diagnosis on those signs; at the same time, it is customary now-a-days to make a demonstrative diagnosis. There is no objection to it. It can be done in a minute. A hypodermic needle was introduced, and clear serum drawn off. There was proof afforded to the eye of the correctness of these signs and the diagnosis.

Well, the patient has no fever now. He has been treated by tonics, iodine to the chest, a little morphia, to relieve pain. The urine, which we should always examine in connection with pleurisy, because pleuritic effusion is one of the local effects of uræmia, presents a normal appearance; clear, neutral, no albumen, specific gravity 1.022.

Here is the patient, and the left side is the side affected, which is usually the case in pleurisy with effusion, while the right side is oftener affected with pneumonia. There is still liquid enough below to give rise to vesiculo-tympanitic resonance above. There is still dullness over the lower portion of the left lung behind, and a change of position changes the line of dullness, though not very greatly, as there does not now remain much of the effusion. The presence of liquid here may be proven also by placing the stethoscope below, where the vocal resonance will be found feeble, while above it will be inreased. We even find here slig ht bronchophony above, the lung being sufficiently condensed for that, the reason being, probably, that the patient has had pleurisy on the left side before, which left old adhesions there and renders the condensation of the lung still greater. I get very little vocal resonance when I place the stethoscope below the line of dullness, but when the patient leans forward and allows the liquid to gravitate forward, the vocal resonance there is well marked.

With regard to the prognosis, there is no danger in this case. Inasmuch as he has had no cough or expectoration prior to this attack we may exclude the idea of phthisis. We should always consider this question in cases of pleurisy, whether the pleurisy may not be associated with phthisis.

The treatment. Is it necessary to perform thoracentesis? Not at all. It is very well to explore and get demonstrative evidence of the presence of liquid, but there is not sufficient amount of liquid there to give the patient any inconvenience, and what there is will be absorbed. There is no need of diuretics or hydragogues in order to diminish the amount of the effusion. They would rather diminish the strength of the patient and impede recovery. Is a blister called for? There is no objection to it. Nothing is required to relieve pain, as that has disappeared. All that is required is to keep the patient warm and comfortable, and give him good diet, and wait for the liquid effusion to be absorbed, when the pleuritic surfaces will come in contact, adhesions take place, and the patient will have recovered.

Editorial Department.

Periscope.

Treatment of Pulmonary Phthisis by Benzoate of Sodium.

In the reports of Dr. Augusto Murri (*Rivista Clinica di Bologna*, 1880, p. 24) the following appears:—

When, from the service of Rokitansky, came the consoling news of the cure of phthisis by benzoate of sodium, the author commenced in his wards its administration, both by inhalation following Rokitansky's rules) and internally, to combat the supposed specific poison which tends to invade the entire organism.

But it was found impossible, in using the five per cent. solution, to administer to any patient the large daily dose of 50 grams recommended by Rokitansky (*Wiener Medicin. Presse*, No. 37-42, 1879) or even the smaller dose given by Schüler (*Berliner Klinis.he Wochenschrift*, No. 45, 1879).

The largest dose it was found possible to administer was sixteen grams; it is, in fact, impossible to make a sufficient number of inspirations to consume these large doses; after inhaling a short time nausea and vomiting renders its further use for the moment intolerable to the patient. Again, it is impossible to administer this large dose internally, for it induces a sensation of burning at the stomach, with great pain in the abdomen and diarrhœa; this is what occurred in the case of a patient determined, if possible, to follow out the treatment, and obliged to give it up on account of the vomiting and abdominal pains it induced; it is true, these troubles cease after a time, but it requires a patient of exceptionally firm resolution to follow the treatment thus far.

This intolerance of the remedy by the patients would not cause its banishment from therapeutics if it gave advantageous results; but in twelve cases of phthisis, where the treatment was continued more than two months, the progress of

the disease was not arrested; in fact, caverns were formed where none before existed, and several of the patients died while under treatment.

Again, it was affirmed by Rokitansky, that the fever ceded immediately, but it was found to continue its irregular course, with, perhaps, just a slight remission at the beginning of the treatment.

The sole advantage seeming to result from the use of the remedy, but that during the first few days only, was greater facility of expectoration and lessening of the cough; but how many remedies less disagreeable and less dangerous have similar virtues.

These experiences in the Bologna clinic do not seem encouraging enough to introduce the general use of this remedy, so much vaunted by Rokitansky in the treatment of phthisis.

The Use of Chian Turpentine in Cancer.

The *Lancet*, October 2d, 1880, contains an article on the subject, by Prof. John Clay, of Birmingham, from which we make the following extract:—

In all forms of cancer, where the turpentine has been taken for six or eight weeks, I have found the administration of a tonic to be of advantage, as it promotes the convalescence of the patient; and if the disease affects the uterus or rectum, it seems to facilitate the escape of the débris from the destroyed mass, and to promote cicatrization. Four minims of the tincture of perchloride of iron, and three minims of liquor strychniæ, taken three times daily, are recommended; and if there be any pain, which often happens after six months' use of the remedy, six drops of tincture of belladonna are added. A generous diet is allowed. Morphia is not advised. The bowels should be kept daily moved, when necessary, by a mild aperient. After the turpentine has been regularly taken for three or four months, I now recommend it to be discontinued for three or four days in the fortnight. It is probable that future experience will show that, after it has been taken for the above-named period, it will be no longer necessary in the majority of cases, but as a precautionary measure it has been generally continued in the manner just described.

There are sixteen cases of cancer of the breast under treatment in the hospital, and a large number are under observation privately. The effects of the remedy in the first few weeks are, the relief of pain, and a diminution in the size of the breast, which is generally more movable, even when apparently fixed to the walls of the chest; this, probably, arises from a diminution of the surrounding cancerous infiltration. Time has not been sufficient, however, to speak with definiteness as to the ultimate results. The clinical facts brought out in this class of cases are very interesting and instructive. There is a great probability that the disease is arrested, as after four months' trial of the remedy the morbid growth has not increased in size. As far as can be stated at present, for therapeutical purposes, the cases appear to be divisible into three classes: 1. The ordinary scirrhus of the breast, with or without surrounding infiltration. 2. Epithelial cancer. 3. Cases of ulceration after previous operation.

In the *first* class of cases great interest attaches to the experiment, as indicating how the solid mass is removed. It appears at present to deport itself as if it were a foreign body, and seems disposed to make its way rapidly to the surface; but in the cases where this has occurred, the growth is not of an active character, for, as the mass comes to the surface a crust forms upon it. This disappears in time, and another forms, while the whole bulk of the mass gradually diminishes in size. It may prove eventually that this is one mode of the removal of the disease. In these cases the growth does not increase in size, but, on the contrary, gradually diminishes.

In the *second* class—*i. e.*, epithelial cancers—the surface of the growth becomes paler at first, then smoother, as if it had been leveled by friction; sometimes some of the nodules slough away. Then a process of cicatrization takes place. There are two cases in which the new tissue around the growth is quite half an inch in breadth. Two others, about one and a half and two inches respectively in diameter, have entirely healed over.

In the *third* class of cases the results are so far favorable that the ulceration has not increased in size, but they have not progressed so favorably as the other cases. In several instances the glands of the axilla have been enlarged, but the enlargement has generally disappeared under a steady use of the turpentine.

Anæsthetics in Labor.

Dr. Herriott, in his report on Obstetrics to the Illinois State Medical Society, published in the St. Louis *Medical and Surgical Journal*, October 5th, 1880, says:

The indications for the use of anæsthetics are undue suffering, such as from a rigid os, tension of the soft parts, or irregular contractions of the uterus. Get the patient under mental control and put her gradually but fully under the influence of the anæsthetics for twenty to thirty minutes. Malposition can be corrected during this time. If the patient is not in the act of expulsion allow her to return to semi-consciousness. I have, in three-quarters of an hour, delivered women who would have had to wait from four to six hours.

In primipara the apprehension of evil adds to the nervous exhaustion and the cervix does not dilate as redily.

The anæsthetic quiets undue nervous excitement, husbands the strength, restrains reflex, irregular and excessive uterine contractions. The normal uterine action is increased and not diminished under its influence.

In what special cases are we to refrain from the use? I answer in no case, unless no benefit can be obtained. I have used twenty grains of chloral hydrate and followed with chloroform.

In a letter, Dr. Darrah, a member of this society, says that anæsthetics have a moral effect in encouraging subsequent pregnancies. He would not use them in cases of inertia and

anæmia, where no special demand for them existed.

Dr. Wheeler Jones, our Vice-President, wrote to me that he had used anæsthetics in labor twelve years. He notes especially the moral effect, but refrains from the use in the first stage, except if eclampsia exist; he also refrains from the use in cases of organic disease of the heart.

Scrutinize your patients and exercise care, and scarcely a case will be found in which organic disease does not prevent gestation to full term. Anæsthetics in such cases as arrive to full term can and ought to be given. So in regard to hemorrhage, it ought not to deter us unless absolute danger exists.

I had a case where there was great suffering, and twice, previously, parturition had occupied from sixteen to seventeen hours. I gave chloroform and the labor occupied four and a-half hours; lasting two and a-half hours after administering the anæsthetic. In fifteen minutes after birth the placenta was expelled and less than the usual amount of hemorrhage ensued.

The time to commence the use of an anæsthetic is when the patient without it would suffer; and the time to withdraw it, is when the patient without it would not suffer.

The Hypodermic Administration of Quinine.

Dr. James T. Whittaker says, in a communication to the Cincinnati *Lancet and Clinic*, Oct. 9, 1880—

During the past six months I have made numerous experiments with the subcutaneous injections of quinine in cases of pronounced or masked malaria, where the condition of the digestive system prevented its absorption when administered per os. It is useless to state that the efficacy of the remedy depends altogether upon the amount absorbed by the tissues, and not upon the amount introduced into the stomach. It is now well established that quinine will act when injected into the rectum with the same value as when taken per os, and this is a favorite method of its use in children; but a rectal injection, or repeated rectal injections, are not permitted by adults, and if permitted, are at last no longer retained. In all cases a few drops of tincture of opium should be administered with them.

I have, in practice, entirely discarded all vehicles except water, and rely solely upon heat to obtain a perfect solution. I have the druggist put into a test tube twenty grains of the bromide of quinine and add to it two drachms of water. The tube should be corked, not to preserve the substance, for it is still crystalline in this proportion, but for cleanliness. To use the drug, all that is necessary is to heat the tube over a gas flame, coal oil lamp, or other means of illumination. The tube should be held above the light, of course, and not in it, that it be not smoked, and hence rendered opaque. Two or three minutes suffice to reduce the quinine to a limpid, crystalline fluid in the tube. Thence it is poured in sufficient quantity into a teaspoon, previously warmed by holding one minute over the flame, and from the spoon it is taken up into the syringe, warmed also in the same way, and is ready for use, which must be immediate. It may be injected anywhere, but always *under* and never *into* the skin. The ordinary syringe contains half a drachm, and this introduces about five grains at a time.

I have never known a patient to object to the reintroduction of the needle for the injection of ten or fifteen grains, if need be. The whole operation, no previous preparation being necessary, occupies about five minutes' time, not a tithe of that often consumed in irrelevant conversation.

The Care of the Teeth.

Dr. C. S. W. Baldwin, in a paper on "Dental Hygiene," an abstract of which was published in the *Dental Cosmos* for October, 1880, says:—

Not one-half the people who come to my office use both sides of the mouth in mastication. Dr. Watt, of Ohio, says, "The periosteum is more apt to die from lack of exercise than anything else." If our forefathers and the savage had better teeth than ourselves, it was because they used them more; they had coarser food to masticate, consequently had to exercise their temporal and masseter muscles more, which was necessarily accompanied by an increased flow of blood, and with it a deposit of more and better tooth material. When the infant bites on the rubber ring it causes a slight contraction about the crypt of the outcoming tooth and an absorption of the alveolar process immediately over it; and, better than that, produces slight inflammation, which induces the blood to hasten to its aid, bringing with it material which, in a healthy system, builds up sound teeth.

Dr. Thomas, of Detroit, believes that the only way to induce people to care for their teeth is by a system of education from their childhood. Give the child an account book in which the parent is to be charged one cent each day that the child brushes its teeth three times thoroughly, and the child is to be charged a penny for every failure to do so. In the end this will be a paying investment to the parent.

In cases of white, chalky teeth, where fillings will hold but a short time, no matter how skillfully they may be inserted, I have prescribed preparations of lime with marked improvement. The removal of hyper-sensitiveness to thermal changes is, perhaps, the first sign of improvement; and if this treatment is persisted in, as any constitutional treatment must be, it will produce great and lasting benefits.

In order that teeth may resist caries they must be hard, either by nature or else made so. The thorough use of the tooth brush by children will prevent the deposit of that disgusting green tartar the result of which is seen in gold fillings on the labial surface of the superior incisors. They should be instructed in this as well as in the proper use of the jaws in mastication.

It is a good plan to test the saliva of patients, and if found to be acid to use a mild alkaline solution, such as carbonate of soda or borax, to correct the acidity. I accomplish this by the use of borax in tooth powder. This is also one of the best agents for the prevention of deposits of tartar.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——"The Physiological Action of Urechites Suberecta," is the subject of a paper by Isaac Ott, M.D., which comes to us in the form of a reprint from the *Therapeutic Gazette*, October, 1880.

——A reprint from the *American Practitioner*, for October, 1880, contains a paper on "Puerperal Epilepsy and Protracted Gestation," by L. S. Oppenheimer, M.D., of Seymour, Ind.

——We have just received the Catalogue for the 49th Session, 1879–80, of the Albany Medical College, the Medical Department of Union University, together with the Annual Announcement for the Session 1880–81.

——Dr. Walter Coles, of St. Louis, sends us a report of an obstetrical case with "Intra-Uterine Amputations," and also a paper on the "Relations of the Placenta to Post-partum Hemorrhage, both reprints from the St. Louis *Medical and Surgical Journal.*

——Dr. A. Van Derveer sends us, in a reprint from the *Medical Annals*, for August, 1880, "A Report of Ten Cases of Gastric Ulcer, One Case of Malignant Ulcer of the Stomach, and Two Cases of Perforating Ulcer of the Jejunum," with extracts from a lecture by Dr. Murchison, of London, on the subject.

BOOK NOTICES.

The Care and Culture of Children. A Practical Treatise for the Use of Parents. By Thomas S. Sozinskey, M.D., PH.D., etc. Philadelphia, H. C. Watts Co. Cloth. 8vo, pp. 484. Price $2.50.

All the problems of the future, social, political and religious, will depend for their solution on the education the race receives. Impressed with this far-reaching significance of the word, the author of the work before us has written a treatise intended to instruct those who have the care of the young, especially parents, as to what their full duty is, and to provide them with full knowledge how to carry it out. He has produced a work of great originality and of extensive research. It is divided into two parts.

The first part is called "The Care of Children." This concerns itself, in one section, with such matters as air and ventilation, diet, clothing, bathing, exercise and sleep; and in another section with the rules for nursing them in sickness and brief references to the various diseases to which they are subject. Pretty much all the ascertained principles of hygiene will be here found, and a sufficient amount of information as to diseases for the intelligent general reader. The best recent authorities have been followed, and there is an entire absence of any of that hobbyism or pseudo-scientific nonsense which disfigures so many popular books on sanitary subjects. The author is thoroughly in unison with the best judgment of the regular profession, and his work is a sound exposition of its teachings.

The second part of the work is entitled "The Culture of Children." Here the author takes up the education of the young in its broad sense. The first half is devoted to Physical Culture, the second to Mental Culture. Evidently long reflection and extended study of the various methods of education recommended by the great masters of the art have been here brought to bear on the subject. The organs of sense, and the muscular system, with its external coverings, are all capable of a harmonious development, an extended improvement, by which they become more and more valuable servants of the thinking mind within. The rules for this laid down, the author proceeds to the culture of the mind itself. After general remarks on the subject, he pursues it under the headings of the culture of the feelings, the intellect, the will, the social sentiments and the religious sentiments. His instructions are not repetitions of trite maxims, but the expression of the results of modern psychology, a real example of the application of scientific investigations to the daily wants of the household. The extensive dissemination of this work throughout the length and breadth of our country cannot but result in incalculable benefit to the future of the population, to their physical comfort and to their moral well being.

The Compend of Anatomy. For Use in the Dissecting Room and in preparing for Examinations. By John B. Roberts, A.M., M.D., etc. Philadelphia, C. C. Roberts & Co. pp. 191. Price $1.25.

The object of this work is sufficiently stated in the title. The author is so favorably known, both as a teacher of anatomy and an able surgeon, as to insure the meritorious character of anything he puts forth. The general arrangement he adopts is that of Gray, and he endeavors very successfully to give the greatest amount of information in the most condensed form. We recommend the volume to students.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

THE PURPOSES OF A SCIENTIFIC SOCIETY.

The first scientific society in this country was founded by Dr. Benjamin Franklin, in Philadelphia, in 1743. He wrote at the time a brief circular, stating its purposes, and by implication, the purposes of any such scientific association or assembly. His views are characterized by that sound sense and judicious liberality which were the distinguishing marks of his mind—certainly the strongest mind which this western world has yet produced.

He recognizes in this circular, as the two main objects of such a society, first, the increase of knowledge; second, the dissemination of knowledge. Well, the reader may say, there is nothing new in these statements; everybody knows them. Very true; so also there is nothing new in the Golden Rule; everybody knows that; but it is always a startling and generally incredible novelty to see it carried out. We have now a great many scientific societies, more, probably, than Franklin ever dreamed of; but how many of them hold steadily in view the two universally recognized purposes of their existence which he laid down?

Are the members usually incited to write papers and deliver addresses by a desire to increase knowledge? There is hardly a volume of transactions that does not contain labored articles which would be rejected as the thesis of a medical student by any critical teacher; there are generally other articles in these volumes which are plainly and palpably *reclames*, bids for reputation, and intended solely to gain practice. The publication committee knows this, but these committees belong notoriously to the invertebrate order of creation. Take the last meeting of the American Medical Association. More than one medical journal has straightly charged it with allowing itself to be used as an advertising medium, not only by tradesmen in medical supplies—let that pass—but by its own members, for their own petty purposes. Is it not high time that heroic measures be adopted to put a stop to this?

But we pass to what Franklin defines as the second object of a scientific society, to wit, the dissemination of knowledge. It should clearly be the aim of a society to give any increase of knowledge it has elicited as early and as wide a distribution as possible. It owes this, both to its members, to other societies and to the public. If it has nothing worth telling, let it keep quiet, and the quieter the better. But if it has what others would be glad to learn, it cannot be too prompt or too loud in its utterance.

Here, we believe, many medical societies most conspicuously fail. We do not refer to such altogether exceptional and curious action as that of the Philadelphia County Medical Society. This Society forbids any report of its scientific discussions, even by the members who take part in them; it prohibits a member who imparts to it a discovery from divulging his ideas outside its sacred precincts, and it forces all who read papers before it to await their appearance in an organ of small size and infrequent issue. This altogether anomalous and peculiar position is, we are glad to say, not

imitated by any other scientific society in this country, and is not likely to be.

Where the criticism more generally falls is in the publication of valuable papers in such shapes that they reach but a very small minority of those who would like to see them. For example, in Brooklyn, New York, are two excellent medical societies, each of which does some first-class scientific work every year. Each of these societies publishes its own proceedings, as does another in Albany, and two or three more elsewhere in the State. So, from Pennsylvania and various other States we have received independent publications by county societies or other small local associations.

Now, if these societies publish in this form because the papers read before them are so trashy that they don't deserve, and if offered, could not get, admission to periodicals which would assure them a wide reading, no objection can be made to this sacrifice of a few dollars to personal vanity. But, we frankly say, this is not the case. There have appeared some admirable articles in these unknown and unread ephemeral issues. Abstracts scarcely do them justice, yet that is all the scissoring editor will give them.

We can go a step further, and say the same of transactions of State societies. They are read by very few in the State, and by scarcely anybody outside. To bury a good paper out of sight and out of mind, a sure recipe is to have it sandwiched between the flowery and unctuous "address of the President" and the necrological report of the remarkable, genial and eminent men who have recently died, always reappearing in the ordinary Transactions of every State medical society. It is refreshing to see that this is beginning to be appreciated, and we are not surprised that it is from Kentucky, whose enlightened profession holds such an enviable position in the history of American medicine, that the good news comes.

At the last meeting of the Kentucky State Medical Society a resolution was adopted, by which the Society discontinued the publication of a volume of transactions, simply publishin the minutes in pamphlet form. Papers read before the society may be printed in the regular medical journals selected by their authors. A resolution was also offered and laid over for consideration at next meeting, providing for the creation of a prize-essay fund, by the appropriation to this purpose of the money heretofore used for printing the transactions.

This is as it should be; and if every other State follows Kentucky's lead we shall have a realization of Franklin's scheme, such as will benefit the profession in many ways. There will be less self-adulation, a severer test of merit, and a more prompt and certain recognition of it when it exists.

Notes and Comments.

Phenic Acid as an Antipyretic.

At a late meeting of the Academy of Medicine, of Paris, a member read a memoir, which had for effect to demonstrate that, 1, phenic acid administered in sufficient doses was a reliable antipyretic, suddenly lowering the temperature: 2, that the temporary fall can be maintained and increased by renewing the dose, and that, thanks to this agent, the doctor can moderate at his will the temperature of the patient; 3, that the doses of phenic acid previously considered toxic can be exceeded without danger. He cites examples in which patients have taken two and three drachms daily, for several consecutive days; 4, that it should not be administered by the rectum. The conclusions of the above memoir were based upon five observations of typhoid fever, one of small-pox, one of puerperal peritonitis, several of phthisis, and experiments made on animals.

Dr. Schultz, of Bonn, states that the oil of eucalyptus is devoid of toxic properties, and that it appears to offer to him the various advantages of phenic acid, without the inconveniences attending on the latter. It is a powerful disinfectant, and mixes easily with alcohol and oil, and the odor is agreeable.

Creasote in Phthisis.

The suggestion of creasote in phthisis is by no means new. Recently it became the subject of a discussion at one of the French medical societies, started by a paper by Dr. Boyer. In answer to inquiries, he replied that he directed

his treatment mainly against the abundant expectoration, the profuse sweating, the diarrhœa, etc., which reduce the strength of the patients. Out of fifty patients who presented these symptoms, eight might be said to have been radically cured. The creasote appears to exercise a direct influence on the pulmonary phenomena, the primary cause of the above manifestations, and consequently the patients increase in weight in a manner regular and continuous. M. Grenet said he employed creasote where vomicæ existed, but did not obtain good results from it. Arsenic and cod-liver oil have, on the contrary, procured ameliorations which manifested themselves in certain patients by an increase of weight. He would ask M. Boyer why he objected to cod-liver oil, which proved its efficiency over and over again, and in what form of phthisis and in what dose he administered the creasote? M. Boyer, in replying, said he preferred creasote to arsenic and cod-liver oil, because the results appeared to him more constant and rapid. He had also recourse to glycerine combined with iodide of potassium, because this medicine is easily borne and accepted by the patients. In painting the thoracic walls with tincture of iodine, he considered that enough iodine was absorbed without having recourse to cod-liver oil. He administered the creasote as follows:—

℞.	Creasote,	ʒij
	Rum,	ʒiv
	Glycerine,	ʒiv.

One or two tablespoonfuls to be taken daily, after meals, in a little soda water.

It was in the torpid and scrofulous forms of phthisis arrived at the second stage that M. Boyer used the above mixture.

The Quality of Infection.

The following sensible remarks appear in a little pamphlet by Dr. David Page, of Edinburgh:—

"Infectious diseases exhibit widely different degrees of severity, but it is well to bear in mind that the slightest and most incipient degree is as intensely infectious as the most alarming and developed, and that the same unrelaxed precautions are required for the one as for the other. Mildness of attack is only a matter of good fortune to the sick person thus attacked, and gives no security whatsoever to the healthy.

"Do not forget that infection is a quality of the fever poison, and not altogether one of dose or length of exposure. The mildest case and a moment's exposure may give the infection and the disease in its most malignant form, the issue depending upon the state of the individual and his sanitary surroundings at the time, or in other words, *the seeds of infection are always the same, the result depending upon the soil in which they happen to be sown.* I have known some of the worst and most fatal outbreaks of scarlet fever to have been preceded in the affected households by the mildest possible attacks.

"Children are the great nursery of infectious disorders of all kinds, but it is a most mistaken notion to look upon these disorders as ailments which children are bound to have. No child is bound to have scarlet fever or diphtheria; not even measles; and to have any one of these diseases points to bad hygienic conditions, and generally to some one's ignorance or neglect."

Digestion in Plants.

Dr. Lawson Tait has recently investigated afresh the digestive principle of plants. While he has obtained complete proof of a digestive process in cephalotus, nepenthes, dionœa, and the droseraceæ, he entirely failed with sarrencenia and darlingtonia. The fluid separated from the drosera binata he found to contain two substances, to which he gives the names "droserin" and "azerin." Dr. Tait confirms Sir J. D. Hooker's statement that the fluid removed from the living pitcher of nepenthes into a glass vessel does not digest. A series of experiments led him to the conclusion that the acid must resemble lactic acid, at least in its properties. The glands in the pitchers of nepenthes he states to be quite analogous to the peptic follicles of the human stomach; and when the process of digestion is conducted with albumen, the products are exactly the same as when pepsine is engaged. The results give the same reactions with reagents, especially the characteristic violet with oxide of copper and potash, and there can be no doubt that they are peptones.

Quinine as Inducing Labor.

A writer in the *Lancet*, October 16th, says that, at least in India, there can be no doubt but that quinine does induce labor. He instances the following case:—

A lady expected her confinement at the latter part of August. In the middle of July she had fever of an intermittent kind; on the 7th of August the doctor gave quinine, in five-grain doses, three times a day. She took two doses—one in the morning and the second at mid-day. At about 8 o'clock in the evening, without any warning, the "waters burst," and slight uterine pains came on. They were, however, very

slight—so much so that she doubted whether she was in labor at all, until at about 11 o'clock the pains became a little stronger; one or two sharp pains succeeded, and the child's head was born, followed after a few moments by the body. The placenta came away about half an hour afterward without hemorrhage. The child was very small, and looked as though it had been born a month before its time.

Trichinosis in American Pork.

The *Revue d'Hygiène*, of August 15th, states that American pork and bacon have been prohibited entry into Italy, Austria, Portugal, Spain, and Prussia, on account of the frequency with which trichinæ are detected in it. The *Revue* adds that large quantities have of late been brought to France, where it meets with a ready sale. Information received from some of the towns in the Département du Nord, proves, without any doubt, that trichinæ have been found in the bacon sold by the small retailers. It seems that this bacon is frequently submitted to only very short and imperfect cooking, so that there is great danger of the spread of trichinosis.

Perhaps when they find their markets going out of their hands, the pork packers of the west will understand the value of having sanitary inspectors appointed, as in Germany, who will condemn all trichinous pork as soon as slaughtered.

A Triple Ovary.

Dr. Keppler, a German physician, settled in Venice, on the occasion of his sixth ovariotomy (all successful), found a third ovary, with its corresponding tube, completely developed. According to Rokitansky and Klebs, no such circumstance has hitherto been observed. His case is reported in the *Allg. Wiener Med. Zeitung*, of September 7th.

Supernumerary ovaries merely, are by no means uncommon. Dr. H. Beigel claims to have found them in twenty-three cases out of five hundred autopsies.

International Health Statistics.

At the International Health Congress, recently held at Milan, a project of a general scheme for international health statistics was brought forward by Dr. Ybanez de Aldecoa. His scheme embraced these points:—

1. The reports should be made every ten days, on the 10th, 20th and 30th of each month.

2. The reports to include births, marriages, deaths, and meteorology.

3. The nomenclature and classification of diseases to be identical.

4. Deaths to be classified according to ages.

5. The form of the reports to be identical.

6. Each nation to add to this form whatever may be required by its peculiar situation, etc.

We hope that this excellent project will receive the attention of governments and be adopted ere long.

The Sense of Colors.

M. Charpentier, of Nancy, has propounded to the French Association for the Advancement of Science the somewhat novel theory that the sense of light and that of colors is independent. White light being the sum of the various colors, it has been commonly thought that the sensation of white light was simply the sum total of the sensations of its constituent colors. On the ground that the sensitiveness of the eye for white light may be increased—as, for instance, by the previous absence of all light—without the sensitiveness for color being increased, he urges that there is a color-sense as distinct from that of light as is the sense of touch from the sense of heat.

Influence of Change of Position of the Body on its Temperature.

Dr. Sasseski, of St. Petersburg, shows, in a recent paper, that the elevation of the upper extremities, and still more of the lower extremities, increases the frequency of the pulse and of respiration, as well as the temperature of the body (taken either in the mouth, the rectum, or the axilla) as much as from 2° to 3.2°, while that of the hands falls to 1.5°. These changes are more marked among the sick, especially those attacked with typhus, than among the healthy. The more advanced is the febrile condition, the more the nutrition of the heart is altered, and the more sensitive it becomes to changes in the position of the extremities.

Prepared Blood as an Article of Food.

The drinking of warm blood, as a remedial measure, has become not uncommon; dried or exsiccated blood is to be had in most drug stores; as an article of diet, "blood sausage" or "blood pudding" is appreciated by all wise *gourmets*; and from a foreign exchange we learn that there has been lately turned out at Milan a new kind of bread, made with blood from raw flesh. It is said to be a preventive of scurvy, and to do away,

among peasants, with all desire for alcoholic drinks. The difficulty of blood coagulation being overcome, the "blood bread" will last for years. Twenty per cent. of its ingredients consists of blood; its cost is only two-thirds of a cent per loaf, and it is more nutritious than the ordinary loaves at one cent each.

The Constant Current in Disease of the Internal Ear

Dr. Ladreit de Lacharriere has an article on this subject in the *Annales des Maladies de l'Oreille*, etc., for September. He had frequently employed the continuous current with satisfactory results, in cases of simple weakening of the acoustic nerves. He has now further come to the conclusion: 1. That there are some morbid conditions of the ear characterized by passive congestion of the labyrinth, caused by weakening of the vaso-motor nerves; and 2, That continuous electric currents are efficacious in modifying these pathological conditions, in removing the tinnitus and vertigo which accompany them, and in re-establishing hearing.

Is Shampooing Advisable?

Dr. Rumbold, in his book on Catarrh, says no! He writes of it:—

This is injurious to the scalp and the hair; it removes every particle of oil from the head, causing the scalp to become dry and full of dandruff, and the hair to lose its glossiness and natural color, generally giving it a faded and a lighter appearance; but worse than this, on account of the absence of the oil, the patient is more liable to take cold, on even a slight exposure of the head to a draught of cool air.

Dr. Leonard, on the other hand, in his book on the hair, recommends that it be washed several times a week with soap and water.

Let us have this question brought to an issue and settled.

Xylotherapy.

This word means "healing by wood." It is the latest step in advance of "metallo-therapy," and is used in the same class of cases, to-wit, those who need no therapeutical treatment; and it is quite successful in that large percentage of that class who will get well soonest by being left alone. M. Dujardin-Beaumetz, of Paris, is its discoverer. He has much to say on the "æsthesiogenic power" of various woods, which we would reproduce did we believe it of any value, and adduces various hysterical cases markedly influenced by the application of wooden discs, which might appear convincing to any one—if there is any one—who puts faith in the subjective symptoms of nervous women.

The Crematory Process.

The Italians favor cremation more than any other nation, the crematory at Milan being well patronized. A recent correspondent states that all around the furnace are placed small, square, glass peep-holes, which allow of the phases of the combustion being observed. The skin soon becomes carbonized, and then the bones; and it is only somewhat later that the viscera issue from the holes burned in the chest and abdomen, the liver being the organ that resists the longest. At the end of two hours pulverization is quite complete. All this takes place without smell or noise.

Dangers from Steel Pens.

M. Galezowski has informed the Paris Société de Médecine Publique et d'Hygiène Professionnelle that he has noted fifty cases of serious accidents to the eye in schools, due to the introduction of steel pens into that organ. He is therefore of opinion that the use of metallic nibs should be abolished in educational establishments. Whether such numerous accidents occur elsewhere is doubtful; but we have heard of enough in this country to make it worth while to quote his advice.

The Mortality of Physicians.

Dating from the horizon of South Germany, Prof. von Hecker, of Munich, finds that in the first ten years of their professional life (twenty-four to thirty-four) about six per cent. of physicians die; while in the next decade (thirty-four to forty-four) more than twelve per cent. meet their end. He attributes this to exhaustion from excessive labor, neglect of slight ailments, and also to the abuse of alcohol and opium (morphine), which latter he believes is more common among the members of the medical than any other profession.

Baths of Blood.

In a recent work on rheumatism, Dr. Vovard, at Bordeaux, narrates the case of a young lady who, from lying in the grass while in a perspiration, had an attack of acute cellulitis of the arm, followed by muscular atrophy and loss of use of the limb. Electricity and counter-irritation hav-

ing failed, the limb was considerably recovered by bathing it in blood of animals freshly killed—a plan of treatment advocated by the celebrated Lieutaud, whose works a century ago achieved great fame, and a plan not unfamiliar to some medical lights of antiquity.

A Dangerous Imposition.

At a recent meeting of the Albany Co. Med. Society, Dr. Charles A. Robertson exhibited a picture cut from an advertisement, representing a cup, about to be applied over the eye of a person by the hand, which holds an elastic india-rubber ball. Below was the text, printed in capitals, with exclamation points to match.

"RESTORE YOUR SIGHT! SPECTACLES AND SURGICAL OPERATIONS RENDERED USELESS! THE INESTIMABLE BLESSING OF SIGHT RENDERED PERPETUAL BY THE USE OF THE NEW PATENT IMPROVED EYE-CUP."

Above, in displayed type, it is announced that Mrs. Rev. Henry Ward Beecher, after using the ivory eye-cups, orders a pair for the wife of Rev. Charles Beecher, of Georgetown, Mass. Dr. Robertson added:—

"I deem it a duty to utter a warning against the employment of this cupping apparatus as not only a sheer imposition, since it is false in principle, but as also exceedingly dangerous to the well-being of the eye. It is an old contrivance for the purpose of gain, and palmed off regardless of the consequences that dupes may suffer."

Injurious Effects of Salicylic Acid.

Several injurious effects of salicylic acid and the salicylates have been recently reported. That they diminish the digestive power, seems pretty well ascertained. A case of sudden blindness lasting ten hours, induced by the medicinal use of salicylate of soda, has been reported by Dr. Gatti, an Italian physician; while in the French medical journals several cases of complete impotence are stated to have resulted from the same cause. In all these accidents the nervous symptoms were temporary, recovery of the functions taking place after ceasing the use of the medicine.

Spanking and Flogging as Therapeutic Measures.

A year or two ago Dr. I. E. Taylor showed the excellent effects to be derived from spanking the child and flogging the mother (with a wet towel), in some of the accidents of parturition. Dr. Heurot, of Paris, has found the same measure admirable as a remedy in hysterical spasms. We recollect that, as a small boy, we took some doses of this same preparation for certain emotional diseases, such as slight kleptomania (toward apples), acute ira, and disorder of the organs of speech (prophania); in these and similar disorders, we join in giving it our fullest recommendation.

Correspondence.

Ovarian Tumor Complicated with Pregnancy Successful Operation.

Ed. Med. and Surg. Reporter:—

I was called in consultation with Dr. Thomas Carson, June 20th, 1880, to see Mrs. C. M., aged twenty; married December, 1879; always had good health up to present illness; good family history. About February 1st she ceased to menstruate; she thought she was pregnant, and although soon after this she began to fail in health, she did not call a physician until about April 1st. From this time until I saw her she had been confined to bed; had suffered but little pain, but was weak and had difficult breathing. At my visit I found the abdomen enormously swollen, very much prostrated, rapid pulse and oppressed breathing. After careful examination I made diagnosis of ovarian tumor with pregnancy, which was concurred in by the attending physician. I recommended that the tumor be aspirated, and that the pregnancy be left alone for the present, in the hope that abortion would take place before the tumor would again fill. This being agreed to, I aspirated the tumor and withdrew thirty pounds of fluid serum. The gravid uterus could then be distinctly felt, and there now seemed to be no doubt as to the correctness of the diagnosis. The operation was followed by great relief, and the patient improved in a general way every day.

On July 1st miscarriage occurred, and a seemingly well developed fœtus of five months was delivered, everything occurring in the natural way, and was followed by no bad symptoms. The tumor at once began to fill, and by July 31st was almost as large as at my first visit. She was suffering greatly from dyspnœa, rapid pulse and fever. I again, at this date, aspirated the tumor, but found the contents to be *pus*. I partly evacuated the tumor, withdrawing seventeen and a half pounds of pus, with but little relief to patient. I then informed the patient that her only hope of life, beyond a few weeks, was to submit to an operation for the removal of the tumor, and the case would not admit of delay. After two weeks' deliberation, she finally consented to have the operation performed.

On the 16th of August I performed the operation, assisted by Dr. Thomas Carson, Dr. John Carson, Dr. W. T. Larimer, Dr. W. W. Leech, and Dr. W. W. Johnston. Her condition seemed to be almost hopeless. Coated tongue, pulse

120, temperature 103.5°, extremely prostrated. It is not my intention to go into the full details of the operation, as they are in many respects familiar to all, but simply to refer to some of the more important points. The Lister spray was used, and full antiseptic precautions taken in detail. The tumor was multilocular, the larger cyst containing pus, the smaller ones serum (proving that even the small point of the aspirating needle may cause inflammation of the cyst-wall). The tumor was adherent to the omentum and to anterior surface of abdomen in several places, quite firmly. The adhesions were all separated by the hand, except that of the omentum; this was ligated and cut, leaving ligature on omentum. The pedicle was ligated by double ligature, linked, as suggested by Emmet.

And now comes what I deem the most *important* part of the operation, the *thorough cleansing* of the abdominal cavity. *One hour* was spent in this; bleeding or oozing points upon the surface of the abdomen, that did not *entirely dry* by hot water and Monsel's solution, were carefully lifted by tenaculum and a small ligature passed around and cut close. In this case seven points were so ligated; sponges were used until they returned clean from all parts of abdominal cavity. The abdominal wound was closed with silver sutures, and the surface of abdomen covered with salicylated absorbent cotton, covered with oiled silk and retained by adhesive plaster and bandage. The tumor and contents weighed thirty-five pounds. Not an untoward symptom occurred. She rallied from the operation well. Not a dose of anodyne or *any other* medicine was used after the operation. She was moderately nourished by beef tea, etc., during first week; solid food allowed after that. The external wound healed by first intention throughout; the high temperature and rapid pulse soon began to improve, and in two weeks were normal. At this date, Nov. 1st, the patient is walking about, with every prospect of regaining good health. J. L. Crawford, M.D.

Saltsburg, Indiana Co., Pa.

Tinea Capitis.

Ed. Med. and Surg. Reporter:—

In answer to the request of Dr. S. H. B., of Texas, about the experience of others in the treatment of *tinea circinata*, I beg leave to offer him the following treatment, which has been invariably followed with success:—

℞. Argent. nitratis, pulv.,		℈j	
Hyd. oxid. rub.,		℈ij	
Plumb. iodid.,		ʒj	
Cerati,			
Vaselinæ,	āā	ʒij.	M.

Ft. ung.

Sig.—Rub a piece the size of a bean well into the diseased surface, until it disappears; repeat night and morning.

Three or four applications have frequently proved sufficient.

John F. O'Callaghan, M.D.

1500 *Wharton Street, Phila.*

Leucoderma Africanus.

Ed. Med. and Surg. Reporter:—

There resides in Goshen, N. Y., a negro, quite advanced in age, who is a unique example of the skin affection indicated by the heading of this paragraph. The question, "Can the Ethiopian change his skin?" is answered affirmatively in respect to the colored individual referred to. The transformation has been in gradual progress for several years, until, at the present date, the man, formerly of typical negro blackness, has become of fair Caucasian whiteness, in at least half extent of surface. He is, as always happens in leucoderma, of course, piebald as regards the transformation. Altogether, as a personal rarity, and as an extraordinary specimen of a dermatological lesion, the colored individual who is the subject of this notice is a decided curiosity. J. H. Thompson, M D.

Goshen, N. Y., October 26th, 1880.

News and Miscellany.

Pamphlet Boxes.

For some months we have had in use in our office a number of pamphlet boxes, devised by Mr. T. C. Clacher, of New York City. Usually such inventions are nuisances, and are thrown away after a short trial; but of these we can say that they really are convenient, neat and handy. Below we give a cut of them, which will explain their mechanism.

Full descriptions, prices, etc., can be had by addressing Mr. Clacher, 107 East 28th St., New York City.

Diseases of Workmen in the St. Gothard Tunnel.

This Alpine tunnel will, when completed, be nine miles long, and thus much the longest in the world. It is expected to be open by May next. The later borings have been effected at a great cost of life. The laborers work at a temperature of 89° to 93° Fahr., with the air saturated with moisture. They often work up to their knees in water, and the advance-galleries are so long, that they are only ventilated with great difficulty. ventilation, indeed, being quite insuffi cient. There being four hundred workmen en-

gaged in a space within which are also fifty horses, smoking lamps, the blasting of rock, with ordures which are left for far too long a time, the air becomes rapidly vitiated, while it is not renewed frequently enough. The medical service, too, is quite insufficient. The morbid phenomena observed in the patients who are obliged to quit their employment are of a very grave character. They are in a state of fearful exhaustion. Transfusion has been tried without any good effect, and tonics are of no use. At the autopsy, the liver is found in a fatty condition.

The Third International Congress of Hygiene.

This Congress met at Turin, Sept. 9–12. The Hon. President was Count Ferraris, of Turin, the Acting President, Prof. Paschioff. About one hundred and fifty members were present, among whom were the well-known hygienists, Profs. Fauvel, of Paris, Crocq, of Brussels, Finkelnburg, of Bonn, Vidal, of Paris, Jæger, of Amsterdam, etc.

Among the subjects discussed were obligatory vaccination, the purification of drinking water, the importance of general popular instruction in hygiene, etc.

The next place of meeting was fixed for 1882, at Geneva.

On the adjournment of the Congress, it was invited, and went in a body, to Milan, to observe the cremation of a cadaver in the furnace erected there for that purpose.

Infant Mortality in France.

M. Paul Leroy-Beaulieu calls attention to the increase of infant mortality in France during the last thirty years. Between 1840 and 1849 the number of deaths of children below one year (of every 1000 births) was 140; from 1850–59 it was 172; from 1860–69 it had increased to 175; and it rose during the last decade to 178. A striking feature in connection with this branch of social politics is the increase in the number of stillborn children, and particularly in the case of illegitimates. Dr. Daremburg, in an article in the *Journal des Debats*, attributes this unsatisfactory state of things in a great measure to the increase of crime, and believes that infant mortality is largely affecting the decrease of population.

A Physician's Protective Register.

A company has been formed in this city, under the name of the Physicians' Protective Register Company, and has issued an address to the public stating that their object is to protect the public, and incidentally, the profession, from quack doctors, by the publication of a register of physicians, from which the names of quacks will be omitted.

It appears to us that the proper authority to issue such a register—if any one—is inside the profession and not outside of it. We have little sympathy with a scheme which looks so much like philanthropy in search of business.

Items.

—Swimming is advocated in San Francisco as a cure for the opium habit.

—Dublin continues to be a very unhealthy city. During the thirteen weeks ending October 2 the death rate averaged 34.6 per 1000, against 21.3 in London, and 21.8 in Edinburgh.

—Various prophets predict all sorts of epidemics and widespread diseases next year and the following ones. Some base their predictions on the planetary combinations, others on the "affinities of disease."

—A woman in North Leavenworth, Kan., not long ago, read somewhere, that to fill one's ears with water will make one more intelligent. She tried the experiment three or four days, and her nurse now communicates with her by means of the sign language.

—New medical colleges have been established as follows: one at Memphis, Tennessee, the "Memphis Medical College," Medical Department of Southwestern Baptist University; and one at Little Rock, Arkansas, "Medical Department of Arkansas Industrial University."

—An inquest was held at Liverpool, a fortnight ago, on the body of a shipwright named Robert Willey, who died from erysipelas, after being tattooed by a West Indian "professor" a few days previously. The West Indian was examined, and said he had tattooed hundreds of thousands of persons without ill effect. The deceased was said to have been a man of somewhat unsteady habits. The jury gave a verdict of death from erysipelas, induced by the tattooing.

OBITUARY NOTICE.

THOMASON.—Dr. T. J. Thomason, of Perrineville, N. J., died of a cancerous affection of the tongue, at that town, on the 20th of last August. He was born in Philadelphia, October 12th, 1833, and took his degree from the Pennsylvania Medical College. He soon after settled at Perrineville, where he acquired an extensive practice, and where he passed the remainder of his life, enjoying the esteem of the community and the respect of the profession. In the years 1873–4 he was elected President of the New Jersey State Medical Society. He was a man wrapped up in his profession, giving all his time, energy and ability to it; and many a sufferer now living can bear testimony regarding his great professional skill and success.

QUERIES AND REPLIES.

Dr. B. W. P.—We have not ourselves used the stethoscope you ask about, but we hear it well spoken of.

Dr. R., of Ill.—The dose of belladonna in horses is one to two drachms of the extract.

Dr. Alponse.—Surgeons on passenger steamers are appointed by the companies. *Influence* has most to do with the appointments.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1238.] PHILADELPHIA, NOVEMBER 20, 1880. [Vol. XLIII.—No. 21.

Original Department.

Lecture.

ON FIBROID UTERINE TUMORS.

BY DR. R. S. SUTTON,
Of Pittsburg, Pa.

Delivered at Passavant's Hospital, October 5, 1880.

Gentlemen—You will probably remember Mrs. O., the patient who came before you a year ago, having a fibroid tumor, located in the wall of the uterus on the right side. She was taught the proper method of using hot vaginal douches and put upon a combination of fluid extract of ergot and muriate of ammonia, and sent home. Under the care of Dr. O'Connor she has followed out faithfully this treatment. She was readmitted by request of Dr. O'Connor a few days ago. An examination reveals the fact that the tumor can no longer be found. This is unexpected, but these tumors do occasionally disappear, even without treatment, and this is the second case in which I have seen the tumor disappear while the patient was taking this combination.

As this is the only patient I have to bring before you to-day, we will spend the remainder of the hour talking of fibroid tumors as found in or attached to the uterus. The round, hard fibroid, not the fibro-cystic variety, which we may take up again, will be our topic. On this plate I show you a number of fibroid tumors, all of which have been removed from the uterus. This one was sub-peritoneal; it has undergone cretaceous degeneration, was firmly fixed low in the pelvis, and completely disabled the woman, from pressure on the sacral plexus, and was constantly exciting attacks of localized peritonitis. It was removed, some of you will remember, through the posterior vaginal wall. This one was interstitial, and was removed post-mortem through the vagina. These two are of the submucous variety, and were successfully removed several years ago. This one is the typical fibroid polypus, large as a turkey egg, and showing the point of attachment of the pedicle, which a few days ago I severed with the wire ecraseur. The patient from whom this was removed is already running about and is very well.

This division of fibroids is, of course, arbitrary, for all have the same structure, but it is, for the purpose of teaching and really understanding, convenient to thus divide them. These tumors develop by a single nucleus in the wall of the uterus, and are, by the contractions of the organ, forced either toward the covering membrane or the lining membrane of the organ. In either case they may or may not become pedunculated. If the growth is sub-peritoneal and not disturbing the patient, it is the part of wisdom to let it alone. If it be distinctly pedunculated and there be good ground for its removal, you need not hesitate. Under carbolic spray, after the manner of Mr. Lister, the abdomen may safely be opened and the pedicle may be dealt with in accordance with our knowledge of dealing with the pedicle of ovarian cysts. But if the tumor be sessile, a portion or all of the uterus above the vaginal attachment may have to be removed. Such a surgical procedure requires the utmost necessity and the most profound hesitation. If the tumor be interstitial or submucous, it may be removed by dilating the cervix and cutting down directly upon the tumor, laying open its capsule. If enucleation be found difficult it may be expelled by full doses of ergot. Sub-

peritoneal fibroids are rarely accompanied by hemorrhage, but the uterus often becomes very deep. To condense the organ and to cut off the blood supply to the tumor, there is nothing better than subcutaneous injections of ergot or ergotine, both of which I have used with most excellent results and without producing small abscess more than once in a hundred injections.

Sometimes a sub-peritoneal fibroid falls into the pelvis and retroverts the uterus and makes locomotion difficult. If it be pedunculated it should be removed, but if the patient will not submit to this you may put her in the genu-pectoral position and push the growth up into the abdominal cavity, thus relieving the pressure on nerves, rectum and bladder, and if the patient can wear an instrument, try to sustain it there. In such a case, after the tumor and uterus are elevated, a copious douche of hot water will contract the vessels and set the circulation in the pelvis right again. You may think such a case not likely to occur, but I have one. For eight years I have never failed for a single day, when in the city, to elevate the tumor and to attempt its support with a pledget of cotton saturated with glycerine. This patient will not submit to an operation because I keep her too comfortable.

If hemorrhage is a prominent symptom in a case of uterine fibroid, you may depend upon it the growth is in the wall of the uterus and likely very close to the lining membrane of the uterus. How are you to manage it? My friend, Prof. Byford, of Chicago, would give full doses of ergot several times a day, and adhere to it until the uterus either expelled it or caused its absorption by pressure. He has been very successful, but the plan has always struck me as not entirely the safest one we may adopt. Dr. Meadows, of London, in order to reach these intra-uterine growths, divided the cervix with scissors, and a week later dilated the weakened cervix, split the capsule of the growth and enucleated it on the spot, or gave ergot for its expulsion. Sponge tents are employed to dilate the cervix; this plan I have tried, and although I got the tumor out, I got also a pelvic abscess for my reward. Sponge tents are dangerous implements and should be used with caution. There are many dilators; that of Dr. Sims, which dilates to the size of a quarter dollar, is a good one; further dilatation may be effected with any of the several instruments which depend upon the expansive force of water for their merit. To enucleate the growth after dilatation is effected, the finger nail is often sufficient. Dr. Thomas has devised a serrated scoop for the purpose. A stout tenaculum, or the double and guarded tenaculum of Dr. Sims, may be used to drag it from its bed.

If the tumor be intra-uterine and pedunculated —viz: a uterine fibroid polypus—it is more easily dealt with. Having dilated the cervix, with a stout pair of volsella forceps you may twist it off, or you may pass over it the wire of the ecraseur and sever its pedicle and pull it through the cervix with the same forceps. If the wire once passes the equator of the tumor, as you tighten it it will slip down on to the pedicle. Beyond the medical and surgical treatment alluded to you may be required to arrest serious hemorrhage in these cases. The best hæmostatic is removal of the growth or division of its capsule if the former is impossible. But if you can do neither, ergot, by the mouth or rectum, or better subcutaneously, will be your first prescription. If the uterine cavity is deep and the cervical canal patulous, you may inject directly into the uterus a fluidrachm of tincture of iodine or persulphate of iron; or a tent may be passed into the cervix, or enough of them to fill it. Then a copious hot water douche may be instituted and followed with the tampon. But let us always remember when a fibroid tumor is producing no special discomfort to let it alone.

Communications.

HOW SHALL WE INTERPRET THE DEVIATIONS OF THE HEAD OF THE INCURABLE EPILEPTIC?

BY J. S. WIGHT, M. D.,

Professor of Surgery at the Long Island College Hospital.

In the *Medical Gazette*, August 14, 1880, appeared an article by me on the Deviations of the Heads of Confirmed Inebriates and Incurable Epileptics, showing the possibility of an epileptic being the offspring of an inebriate. My object in that article was to find some basis for the assertion that inebriety is a disease. That the brain of the confirmed inebriate deviates from the standard brain appears to be a fact, from the considerations then brought forward, and the inference was that a deviated brain would manifest a deviated function; and it may be assumed that deviations of function and structure are the antecedents or concomitants of disease. *Hence confirmed inebriety is a disease.*

The same line of reasoning was pursued in regard to epilepsy. The conclusion that epilepsy is a disease must be admitted by all. Yet the hereditary connection between inebriety and

epilepsy might not be so apparent, but the facts pointed very strongly in that direction; indeed, they did not seem to admit of any other interpretation. And in addition to what was then said the following may now be stated: Alcohol disturbs the coördination of the muscles by interfering with the nerve cells that coördinate the muscles. These nerve cells are supposed to be in the cerebellum. It appears, from our measurements previously recorded, that the region of the cerebellum in the confirmed epileptic is smaller than normal, and that this same region in the confirmed inebriate is somewhat smaller than normal. Now, it would seem to be a reasonable thing to say that the disturbance from a long use of alcohol in the cells of coördination might seriously interfere with a normal heredity of the cells; at any rate, two facts stand in such relation as to lead us to believe that one is the cause of the other: (1) The disturbance of the nerve cells of coördination takes place in the parent, and (2) A diminution of the space occupied by these cells is found in the offspring. This conclusion finds some confirmation (1) from my recorded measurement of heads, and (2) from the fact that the deviated brain of an epileptic often descends from the deviated brain of an inebriate.

The closing paragraph of the article in the *Medical Gazette* reads as follows:—

"In fine, this is not the place to point out the relations of the above facts to the facts of the localization of the functions of the cortex cerebri."

Now, it has seemed to me desirable to say a few additional words on the deviations of the epileptic brain and cortical localizations. In the first place, the following general statement may be made: The two zones of the head on each side of the middle arch and between the frontal and superior arches cover a relatively greater volume of brain in the case of an epileptic than in the case of an inebriate; also a relatively greater volume of brain in the case of an inebriate than in that of the normal individual. The deficiencies in the volumes of the brain covered by the posterior arch in the case of an epileptic have already been mentioned. In the second place another general statement may be made, as follows: That part of the brain covered by the zones near the middle arch contains many of the cortical centres of the muscular system. In the epileptic these zones are relatively large. Hence it must be reasonably inferred that the cortical centres of the muscular system are unduly developed in the epileptic brain.

In this connection it is desirable to introduce some paragraphs from a paper read by me before the King's County Medical Society in 1878:—

"In measuring *skulls* and *heads*, I have made use of the following method—namely: Each mastoid process is made a centre of departure; and the point assumed is at the middle of the surface of the mastoid process, just back of the external meatus auditorius, ordinarily from half an inch to an inch above the mastoid extremity. This point is located nearly in a line with the base of the cerebrum, but it falls somewhat below the insertion of the tentorium; so that some of the cerebellum may rise above this *centre point*, and some of the middle cerebral lobe may fall below a line going from it to the supra-orbital ridge. This point is a mark that can be found at all times.

"The measurements of skulls and heads are made in the following directions from one mastoid centre point to the other:

"(1) An anterior arch just above the supra-orbital ridge.

"(2) A frontal arch over the frontal eminences.

"(3) A middle arch nearly over the coronal suture. In better-developed skulls and heads, the coronal suture is further forward; in less-developed skulls and heads the coronal suture is further backward.

"(4) A superior arch, nearly over the vertex, and about parallel with the axis of the foramen magnum.

"(5) A posterior arch over the occipital protuberance, nearly on a line with the insertion of the tentorium. These are the inter-mastoid arches.

"Also determine—

"(6) A diametrical base line from one mastoid point to the other.

"(7) The greatest transverse diameter.

"(8) The greatest antero-posterior diameter—leaving out the frontal sinuses.

"(9) The greatest antero-posterior circumference—leaving out the frontal sinuses, and measuring somewhat above the occipital protuberance.

"(10) The masto-frontal angle, which is included between the planes of the anterior and superior arches."

From these paragraphs it can be seen where the zones are which the frontal and superior arches limit and which are on each side of the middle arch.

Hence, in the next place, our reasoning would run in the following line: (1) In the standard

conditions of the brain the discharging or motor centres of the cortex operate and coöperate on the muscles, under the orderly direction of the coördinating cells of the cerebellum. In other words, the motor centres and the coördinating centres are so adjusted to each other as to carry out their normal functions. The work of the nerve cells is properly and regularly performed. (2) In the deviated conditions of the epileptic brain, the discharging, or motor centres of the cortex, being relatively large, operate and cooperate with extraordinary energy on the muscles, under the disorderly direction of the coördinating cells of the cerebellum, which are apparently fewer and weaker on account of hereditary influences. The motor centres and the coördinating centres are not normally adjusted. The nervo-muscular apparatus must not only have a coördinator, but the coördinator must be adequate to perform its true work.

And now it may be added, that the temporo-sphenoidal parts of the brain are also covered to some extent by the zones in the vicinity of the middle arch, and, as has already been shown, this region is relatively of large size, and it is very probable that the temporo-sphenoidal parts of the brain are abnormally large, as well as the motor parts above designated. If this be admitted, then we may bring forward another point of importance in this obscure subject. I refer to what Ferrier says in regard to lesions of the temporo-parietal region: "It has, I think, been shown conclusively, that experimental lesions of the cortex in this region in the lower animals—a region in which I claim to have demonstrated the existence of individually differentiated centres of special sense—are capable of producing impairment or paralysis of sensation on the opposite side of the body."

Now let us admit that the cortical centres of sensation are located in this temporo-parietal region. Then, as before stated, in the incurable epileptic, as shown by our measurements, these centres must be relatively large. Sensation, sense, and voluntary motion are sequentially related. And if the cortical centres of sensation are large and active as well as the cortical centres of motion, then it must happen that the exalted activity of the sensation cells would tend to augment the activity of the motor-cells. It is now competent for us to look still deeper into the process of coördination—and we may do so on the basis of the following suppositions:—

1. It is perfectly plain, if there are no centres of motion, there can be no motion.

2. It is also perfectly plain, if there are no centres of sensation, there can be no sensation.

3. It is true that sensation is the antecedent of sense, and that sense is the antecedent of motion.

And then we may ask the questions: Where does coördination begin? 1. In the motor acts? 2. In the sense? 3. In the sensation? May we not rather say, that coördination follows in the wake of the entire process of sensation, sense, and motion? And may we not also say, that motions are coördinated, because knowledge and impressions are coördinated?

From what has thus far been said, it may be understood how some disturbance somewhere in these three steps of intellectual (?) activity may eventuate in some special motor manifestation. 1. Let there be an undue irritation of the sensation-cells, and the effect may be an epileptic fit. 2. Let there be an undue discharge from the motor-cells, and the effect may also be an epileptic fit. 3. Let there be an undue action of both the sensation-cells and the motor-cells of the cortex cerebri, and the effect may be an epileptic fit. And these results are no doubt apt to follow, when the motor and sensation regions of the cortex cerebri are relatively developed in excess, and when the region of coördination is defective in development.

If our reasoning rests on a basis of facts it must agree with the general fact, that an irritative disturbance set up at many points outside of the motor centres may produce an epileptic fit; and such is the case in more than half the cases of epilepsy, as is shown by the various auræ affecting the patients. In this respect the view proposed does not disagree with the facts. To say that the eccentric point of disturbance is the cause of the fit, even though the removal of such disturbance arrests the fits in the future, cannot always give us the entire truth; for we overlook the deviations that may possibly be found in the cortex cerebri; and we can bear in mind that, if the cortical deviations were absent, the local disturbance might in no wise be anything more than a mere local disturbance. So that if we have the proper deviations of the cortex cerebri, a great variety of local disturbances may from time to time throw the machinery of sensation, sense and motion into spasmodic disorder.

Let it also be said that we do not exclude from this view of the subject that more anterior part of the brain which appears to be more especially employed as a higher intellectual centre. It is no doubt true that an irritation may begin there which may cause disturbance in the motor cen-

tres of the cortex and eventuate in epilepsy. The emotions of the intellect have a potential influence on the nervo-muscular system, including the blood vessels. The emotions of the intellect may also have a potential influence on the cells of coördination—deranging the coördinating powers themselves.

It is not my object now to go into this subject further than in the most general way to draw attention to the facts, that the brain of an incurable epileptic is a deviation from the standard brain, and that this deviation is hereditary, and that it often has its root in the brain of an inebriate parent, and that this hereditary deviation is a diseased condition, which is in some way connected with epilepsy, and that this deviation of organization is the reason why some cases of epilepsy are incurable, and that if we should meet with a head deviating, as the heads of the forty incurable epileptics measured by me were found to deviate, and its possessor having epilepsy, we could quite surely conclude, that the case would be incurable. The facts are, that an epileptic may come from an inebriate, and that the motor area of the cortex—and may be the sensory area—are relatively of large size, and that the posterior part of the head is deficient in size.

In fine, I may close these remarks by a paragraph taken from my previous paper:—

"Looking upon certain individuals as having heads deviating from the standard of volume and conformation, and finding that they are not adjusted to the conditions in which they live, and that they exhibit abnormal functional manifestations, and seeing that the influences of disease and injury augment their deviations: In a given case of injury or disease, we may have, in the deviation of the volume and conformation of the brain, an important indication as to what the clinical history may be, not only immediately, but during the rest of the life of the individual."

HYPOSULPHITE OF SODA IN THE TREATMENT OF DIPHTHERIA.

BY EDWIN BURD, M.D.,
Of Lisbon, Iowa.

About three years ago, while devoting some time to the macroscopic and microscopic investigation of the pathology and pathological anatomy of the prevalent and fatal disease, among some popularly termed "hog cholera," my attention was called to the reputed good effects of the hyposulphite of soda as a prophylactic and curative agent in that disease.

Bacteria being the supposed *cause* of the disease, and the hyposulphite of soda being efficacious in its prevention when properly used, as well as curative in many cases when given in time, led me to reason as follows: Diphtheria is supposed to be caused by bacteria, probably of a different kind from those giving origin to cholera in swine, yet bacteria nevertheless; and as sulphur is destructive to both animal and vegetable life, its use in diphtheria should give good results; and further, as the hyposulphite of soda seemed to give better results in swine than sulphur, I concluded to test the matter in diphtheria, should any cases present themselves for treatment. I called the attention of my friend Dr. J. M. Armstrong, a physician of large experience, to my theories, and he gave them his unqualified approval, and proposed to give the plan a trial in the next case.

My first case was my only son, a little boy five years of age, of delicate constitution, slight in build, who had suffered in infancy from some obscure cerebro-spinal affection, and later from vesical calculus, and consequently had very poor chances in a contest with so dreadful a destroyer. I had the advice and assistance of Drs. J M. Armstrong, W. O. Smith and Geo. Fletcher, of Lisbon, and H. Ristine, of Cedar Rapids. In my state of nervous anxiety and dread of losing my little boy, my theoretical plan of treatment never once entered my mind. The case was of the naso-pharyngo-laryngeal variety, with the urine sixty per cent. in volume, albuminous. On the tenth day of the disease (September 23d, 1879), Drs. H. Ristine and Son, of Cedar Rapids, assisted by Drs. Armstrong, Fletcher and Smith, of Lisbon, performed tracheotomy, which gave the poor little fellow great relief. Very little blood was lost during the operation, and in an hour afterward he seemed quite cheerful, but in a few hours emphysema of the pericardium took place, greatly embarrassing the heart in its action, and twenty-six hours after the operation the little sufferer quietly ceased to breathe.

I write so fully of this case to convince my readers, that I am writing of *diphtheria*, and not of follicular pharyngitis. My only regrets now are, that I did not think of and try my treatment in the case.

About this time, or shortly afterward, my friend, Dr. Armstrong, had a little patient die of the pharyngo-laryngeal variety of the disease. In a short time Drs. George Fletcher and W. O. Smith lost a case, of the naso-pharyngeal variety. In all of these cases, as well as in some who did not die the ordinary plan of treatment, as laid

down by the latest and best authorities, was used. Dr. Armstrong had forgotten the plan of treatment I had laid down, until I called his attention to it, after my little boy's death. He then immediately put it into practice, and has since lost no more cases. He is very enthusiastic over the results. I have used it in eight cases, with flattering results, all of them rapidly recovering.

My plan of treatment is as follows:—

℞. Sodæ hyposulphis, ℈ viij
Quiniæ sulphatis, ʒ ss
Spiritus frumenti, f. ʒ iv. M.

Sig.—For a child five years of age, one teaspoonful every four hours, day and night.

℞. Potassæ chloratis, ʒ ij
Tr. ferri chloridi, f. ʒ ij
Syr. simplicis, f. ʒ iv. M.

Sig.—One teaspoonful every four hours, day and night.

Insufflations of sulphur to be used several times a day. Food is urged upon the little patients in as large quantities as can be digested.

In all cases where the above treatment has been strictly carried out from the start, the result has been surprising. The spread of the exudation is at once arrested, and prostration does not ensue. The fetor of the breath also soon leaves, and the patient soon becomes bright and cheerful. If applied as soon as the first signs of exudation appear, the whole process seems to end right here, and in a few days the patient is well, with no unpleasant sequelæ.

I would urge upon the profession a *thorough trial* of the above plan of treatment, believing that, *if given in time*, it will cure all cases. It ought to prove a good prophylactic also.

CARCINOMATOUS DISEASE OF THE UTERUS—PREGNANCY—10½ MONTHS' TERM—DEATH.

BY I. N. SNIVELY, M. D.,
Of Waynesboro, Pa.

October 19th, 18—, I was called to see Mrs. F., wife of a farmer, aged forty-five, pregnant with her thirteenth child; had her menses the last time the middle of February, and felt first movements of child early in July; lost some little blood per vagina occasionally; suffered great pain in the region of the uterus and in the back; felt entirely different from her former pregnancies, which made her apprehensive that something terrible would befall her; had a discharge per vagina, which she thought was of a leucorrhœal character, from which she felt weakened. Upon examination I found the cervix and os uteri of an enormous size and of cartilaginous and scirrhous hardness, with an irregular and indented surface. The os presented a funnel-shaped cavity which could be entered to the depth of two inches with the index finger. There was a sanious discharge from this ulcerated surface. I was satisfied, from the unyielding nature of this abnormal tissue, sufficient dilatation of the os to allow the expulsion of the contents of the uterus was impossible, without rupturing this organ or the use of the knife. I placed my patient on general and local treatment.

November 6th. Found her stronger—her general condition improved and her local suffering in a measure alleviated. The os continued in the same condition. She expected her confinement the middle of this month. December 1st. Condition the same. December 17th. The same hard, unyielding tissue continues.

January 3d, I was summoned to her bedside. She had slight pains at irregular intervals all night. I found her moving through the house and suffering very little pain, the os making slight efforts at dilatation, but the same unyielding hardness continues. Her general condition was better, but the ichorous discharge per vagina continued. Auscultation revealed the placental souffle and beating of the fœtal heart.

January 4th. I found my patient sitting up, but her countenance changed. Her suffering was very great. She had a chill during the night. Now I could not hear any sounds within the uterus. The position of the child was apparently changed, and she complained of a sense of coldness and weight about her womb. I was satisfied the child was dead. The scirrhous feel of the os continued the same. Her appetite was gone and she complained of great discomfort, her skin assuming a yellow hue. I ordered a gentle purgative. Evening: Her bowels having been moved, I ordered a dose of morphia.

January 5th. My patient slept some during the night. This morning she showed me a viscid discharge she passed per vagina, which I found upon examination to be meconium. There was a breech presentation. She was unable to void her urine, which I drew away with the catheter.

She now suffered great pain about the os, which yielded, in a measure, after the free use of belladonna ointment.

January 6th. I found her very much in the same condition.

January 7th. In the morning I found her suffering with a violent chill which lasted over an hour. After reaction was established her pulse ran up to 170 per minute. I prescribed the usual

sedatives and made her as comfortable as possible. I called the oldest and most experienced physician in counsel, who confirmed my diagnosis.

Evening—Pulse less frequent and no uterine action.

January 8th, 9 A. M.—The generation of gases within the uterus has greatly distended the abdomen. Occasionally gas escaping per vagina from the decomposing child imprisoned within the rigid and diseased walls of the womb.

Her pupils became somewhat contracted, respiration became slow, and the pulse increased in frequency and coma supervened and speedily closed the scene.

She died at 2 P. M., in a comatose condition. An examination revealed a carcinomatous degeneration of not only the os and cervix uteri, but of the walls of this organ.

It is most unfortunate, yet too true, that pregnancy will take place when the uterus is affected with cancerous disease, and the physiological enlargement of this organ during the period of gestation facilitates a corresponding rapidity of this malignant disease.

Waynesboro, Franklin Co., Pa., Oct. 30, 1880.

Hospital Reports.

PENNSYLVANIA HOSPITAL.

SERVICE OF DR. R. J. LEVIS.

Reported for the Medical and Surgical Reporter, by Geo. F. Souwers, M. D.

Fracture of the Fibula.

There are, perhaps, in the wide range of surgery, no injuries that you will be so frequently called upon to treat as fractures of the different bones of the body, more especially of the extremities, and I therefore bring before my classes as great a number and variety of these cases as the wards of this hospital will furnish. In pursuance of this plan, I shall this morning exhibit to you and make some remarks upon a case of fracture of the fibula.

There is about a fracture of the fibula a certain amount of deceptiveness that is apt to throw one off his guard. When the tibia remains intact the fracture in the fibula is apt to be overlooked, but by observing a procedure of which I shall speak to you later, you need never fall into error. If you ask me does not such a fracture immediately disable a man and interfere with his locomotion? I answer decidedly that it does not; very frequently we have coming to this hospital cases that walk in as though their limbs were entirely sound, when upon examination there is found to be fracture of the fibula; indeed, I have even known patients to run quite a distance with the bone in this condition; again, this fracture is not unfrequently mistaken for a sprain of the ankle-joint, on account of the little pain and displacement present.

This bone is generally fractured by reason of indirect or transmitted violence, and when thus caused, the seat of fracture is apt to be two to three inches from the lower end of the bone. In case of fracture from direct violence, the break is more apt to occur exactly at the point upon which the blow is administered. As the lower end of this bone enters into the formation of the ankle joint by means of a flange-like extremity, any solution in its continuity is followed (more especially when the fracture is low down) by greater or less lateral displacement of the foot; normally there is but little lateral movement in the foot, but free lateral movements may be made when fracture of the fibula takes place; further, this motion, if made, is very apt to produce pain; the least bit outward makes the patient wince. Occasionally, in lean subjects more particularly, a little depression of the overlying tissues takes place over the seat of fracture; this, however, is apt not to be observable in fat subjects, so that it cannot be depended on as a diagnostic sign. There is one diagnostic point, however, on which you can invariably rely when the fracture is from two to three inches from the end of the bone. By feeling high up in the leg and just to the outer and back part of the tibia, the upper end of the fibula may be discovered. If, now, at this point, a little pressure be made, the patient at once complains of pain at the seat of fracture, one finger of the disengaged hand being now placed at the point of pain, and pressure being again made above, slight tilting of the upper fragment may be distinguished.

As to treatment, in this hospital we employ the fracture-box almost altogether; in those cases, however, where there is very great and uncontrollable lateral displacement, a Dupuytren splint is employed, the foot being carried strongly inward. The great trouble with this plan of procedure is that the patient does not bear it well, as it is apt to be exquisitely painful. Consequently, in twenty-four or forty-eight hours, or as soon as this tendency to displacement is overcome, the limb is placed in the fracture-box and treated as a case of ordinary fibular fracture.

Fracture of the Vertebræ.

Of late years a form of fracture frequently appears in this hospital which formerly we very rarely saw: I refer to fractures in various parts of the spinal column. During the last six or eight weeks we have had under our care in the wards some three or four patients suffering from this accident. Day before yesterday one of these cases died, but I am enabled to illustrate the remarks I am about to make to you on this subject, by the case of A. B., a laborer, aged about thirty, who is now before you, and who received his injuries by a wall falling upon him, some ten days since.

Fracture of the spine is apt to be the result of a fall, but the accident may happen in other ways. The cause of these fractures may, in fact, be classed under three heads: primarily, direct, violence applied transversely to the vertical line of the column, may be said to be the most common cause; thus, a fracture caused by a gunshot wound, by the passage of a heavy wagon

over the body, a fall of bricks, or of coal in a mine, would be classed under this head.

Secondarily, violence applied indirectly, as when one falls from a height and strikes on the feet, the impact of the blow being transmitted along the bones of the legs and pelvis to the column, is a very common cause of the accident. Where the conditions are reversed, and one strikes on the head instead of the feet, the same remarks will apply.

A third, although uncommon, factor in the production of this fracture, is extreme flexion of the column, especially when this flexion finally meets with resistance, as it eventually does. The greatest amount of motion in the lower part of the spinal column is about the junction of the last dorsal and first lumbar vertebræ, and it is at this point that the most common seat of fracture is situated when the accident is due to extreme flexion. The manner in which this variety of the accident happens is about as follows: A man standing at the bottom of a deep well has a bucket of earth or other material fall upon him; striving to shield his head, he stoops, when the bucket strikes him between the shoulders, forcing the column into a state of extreme flexion, the head of the man being jammed forward and downward. Some few weeks since a man was brought into the institution who was the victim of just such an accident, the accident taking place in a coal mine; paralysis followed immediately, and lasted till his death, some two or three days ago. A post-mortem examination revealed a fracture involving the bodies of the first, second and third lumbar vertebræ; the first being greatly displaced, compressing the spinal cord. This latter symptom (compression of the cord) is, of itself, almost pathognomonic of fracture of the vertebræ, for, being so tightly interlocked and joined to each other, by means of the various ligaments, dislocation of the various segments of the column, and consequent compression of the cord, is almost impossible unless fracture be present. The natural resiliency of the parts tends to drag them back into their proper position, and thus to gradually reduce the amount of compression of the cord.

The spinal column may break, as I have said, at any point, and at any part of each vertebra of which it is composed; the higher the seat of fracture the more serious are the consequences. Thus, if the fracture be situated at or above the third or fourth cervical vertebra, and the cord is completely compressed, death takes place almost immediately, for about this point the phrenic nerve to the diaphragm has its origin. Where compression is but partial life may continue for a while, till secondary consequences set in, these being effusions of blood, inflammation, etc. If the fracture be lower down, the diaphragm's innervation is not interfered with, and the man may continue to live a number of days, or even weeks, till, in fact, the muscle literally becomes tired out and ceases to work. The most common seat of fracture is through the arch, involving generally the laminæ, though the bodies themselves may alone be implicated. The gravity of the accident does not consist in the fracture of the bones, but in the injury which is inflicted to the very important within contained structures. In the case of the man before you the fracture is situated about the first lumbar vertebra; here, while the paralysis produced is serious, yet the compression of the cord taking place so low down, where it begins to split up into fibres that are covered by a dense neurilemma, and where the cord can bear a good deal of compression, involves no nerves or functions that are absolutely essential to life, or that cannot in some way be provided for. Had the fracture taken place in the dorsal region respiration would have been very seriously interfered with, owing to the paralysis of the chest muscles which would have been produced. In all cases of spinal fractures the functions of the bladder and rectum are greatly interfered with; the lower down in the column the seat of fracture the more will this rule apply. The patient, as in the case before you, is unable to micturate or to voluntarily empty the bowels. The consequence is that the bladder, for a few days after such an accident as we have been discussing, is unable to empty itself, the urine, gradually accumulating, finally overflows into the urethra, and constant dribbling of water is the result. This, of course, must be watched and provided for in a manner which I shall explain to you later, when discussing the treatment of such cases. In testing this man's sensation, I find that below the crest of the ilium I can, without giving him pain, thrust a pin into him, but above that point sensation again begins to be manifested. On closer examination of this man I find that there has even been some exfoliation of bone, so great was the amount of violence producing the injury. As a matter of differential diagnosis I may say to you, that if a patient is brought to you having a history of having had great violence administered to him, and there has been *immediate* paralysis following the blow, you can set the case down as one of fracture of the spinal column; if, however, the paralysis makes its appearance after some days have intervened, then you can diagnose the case as one of spinal shock, or of bloody effusions, etc.

We come now to consider the treatment of these cases, and I may at once premise that treatment is not very satisfactory. There is, in fact, no mechanical treatment applicable to the case; of course, if there is great displacement of the fragments we employ extension. Our efforts are rather directed to the mitigation of the secondary consequences than to the relief of the primary trouble.

The patient should be placed in the best possible condition to avoid bedsores, which, owing to defective innervation of the integument, are very apt to supervene, becoming at times so large that the patient is unable to bear up under the tremendous sloughing, and so finally sinks a victim to them. The best way to avoid this disaster is to place the patient on a water bed, which makes equable pressure on all parts of the body, and not on the salient parts only (like the buttocks, shoulders, etc.), as the ordinary mattress does. While the rubber bag, such as I here show you, makes the best and most convenient water bed, yet the expense attached to its purchase is frequently too great for the patient's means. I have devised a plan by which this ob-

jection is to a large extent obviated, while at the same time all the good effects of the bed are obtained. By making a water-proof trough, just large enough to allow the patient to lie in it comfortably (allowing some margin for turning him over, etc.), filling it with water and stretching loosely over it an ordinary gum blanket (costing from $2 to $4), this being just made tight enough to comfortably float the body, a very nice substitute for the more expensive article is obtained. The calves of the legs and the heels must be carefully watched and guarded; these and the other parts of the body liable to bed-sores being daily bathed and thoroughly dried. The bowels should be carefully attended to, as dribbling of fæces is apt to take place, producing great irritation of the integument. The bladder should be catheterized and kept thoroughly washed out, for the urine in these cases is extremely liable to become decidedly alkaline and phosphatic, and these deposits accumulating in the bladder, the urine becomes more or less fetid. To deodorize the water and wash the walls of the bladder, I am in the habit of using a saturated solution of boracic acid, which, being very mild, can produce no evil consequences; at times, also, I employ an injection of carbolic acid. In case of dribbling, a urinal, fitting between the patient's limbs and maintained in position, should also be employed.

Medical Societies.

MINUTES OF THE BIOLOGICAL AND MICROSCOPICAL SECTION OF THE ACADEMY OF NATURAL SCIENCES, NOV. 1st, 1880.

Dr. Carl Seiler in the Chair.

Minutes of the previous meeting were read and approved.

Dr. J. Gibbons Hunt, in referring to a communication made some time ago, said the announcement then made by him, that ciliated epithelia covered the intestines of vertebrated animals, was received with considerable doubt by some of the members of the section.

Since then, a German journal contained a similar statement, which also fully verified his observations.

Dr. Hunt presented for examination some hairs taken from the head of an aged lady, which were of a beautiful carmine color. They were the short hairs underneath the gray, and covered the entire head. They presented no pathological condition. The color is permanent and of a uniform carmine tint. Under the microscope they presented no abnormal appearance.

Dr. Hunt, Chairman of the Committee appointed to prepare a report upon the exhibits and improvements in microscopical science, at the Fifteenth Annual Exhibition of the Section, held Oct. 15th, 1880, read a paper, of which the following is an extract:—

The hall of the Academy was comfortably filled, with, perhaps, two thousand visitors, who were distributed all over the building, the museum being opened and lighted for the fuller entertainment of our guests.

The Entomological Section contributed to our success, by generously displaying a portion of their magnificent collection of butterflies, moths and beetles.

One hundred and twenty-seven microscopes were in position. Of this number, Zentmayer made 48; Beck, 30; Crouch, 23; Bausch and Lomb, 7; Queen & Co., 5; Hartnack, 2; Lidle & Poalk, 2; Gundlack, 1; Ross, 1; J. C. Green, 1; J. H. Steward, 1; Unknown, 6.

Your Committee can look back to the beginning of microscopy in Philadelphia, and at that time, and for a long period after, Nachet's microscopes were the only ones—with few exceptions—then in use. Now, those inferior French instruments are not reported at our meetings.

Many preparations of animal tissues, human and comparative, were shown, such as infected lung, kidney, brain, skin, etc., and some were stained with carmine, then bathed in acid and mounted in balsam, secundum artem obsoletam; and all such looked about as well as could be expected. Best experience, however, is becoming convinced that it is no longer good work to stain only the bioplasts, and to fill the vessels with gelatine colored with carmine, and mount in balsam. Around every bioplast so treated is the cell-body, larger or smaller, which remains invisible. Moreover, growing and *finest* vessels cannot be structurally demonstrated in that way, neither can the connecting tissues which bind all other parts together be demonstrated or studied by these old processes.

Such work has no longer any significance in the entire and correct interpretation of the tissues, but it does create abnormal stomata, and apochryphal perivascular spaces to be found only in the books. Some recent sections, double stained by Cole & Son, of London, were shown at the meeting, and they revealed more tissue elements than any other balsam mounts yet seen this side of the Atlantic.

The division of cartilage—during change towards bone—the so-called osteoblasts, medullary cells and fat-cells, all with bioplasts showing division and vacuolation; not nebulously and doubtfully, but sharply differentiated under 500°, with the binocular, could be seen, educating us more fully into a better understanding of such things.

A beautiful slide of the young bot fly (æstrus gasterophilus) attached to a hair from the horse, is worthy of report.

Living polyps (pectinatella magnifica) and the new rotifer (apœcia emiliæ), intermediate between lascinularia and melicerta, are reported as well chosen illustrations of uncommon pond-life.

In exhibits of plant tissues, by double staining, we saw nothing new.

A new species (cribraria dictydioides) from our Park, is reported on exhibition.

Good slides of microsporon furfur, probably the cause of tinea versicolor of the skin; and of achorion schönleinii, an alleged cause of tinea favosa, or ring-worm, both difficult to obtain and preserve, are reported.

We note a marked advance in the preservation of delicate fungi, and of fresh water algæ. All such were preserved in camphor water one ounce and glycerine about six drops.

Wickerheimer's fluid is unfit for such work. Put all marine algæ in Goadby's solution, and many will be preserved unchanged.

Many beautiful polarizing objects were *well* shown. Æsculine and napthaline were among the most beautiful, but it is an error to exhibit these thin crystals under the binocular with the *second* eye-pieces, because such displays give bad definition. Expertness in microscopic display is best learned—and perhaps learned only—by *much* practice in the resolution of difficult test objects, because in such work greatest attention to illumination and adjustment of lenses is essential, and when that experience is once thus acquired it influences for best results all other displays. We observed many binocular microscopes badly illuminated, without achromatic condensers or an equivalent. This is an error. It is not possible to get best results with the binocular without a condenser below the stage. In all microscopic work command superabundant light. In microscopes some improvements and novelties may be reported for the past year. A small folding microscope, standing very firmly when in use, costing fifteen dollars, exhibited by Queen & Co., is worthy of report.

Beck has removed the flat foot, of whatever shape, from all his instruments, and they all stand on three toes, and are, therefore, steady. His new "International" stand presents some improvements of interest. The stage is 6½ inches in diameter and has ¾ of an inch lateral motion, and nearly that in vertical direction. Motion is given by a screw and rack opposed by springs, which are claimed to obviate loss of motion, a great improvement over his former stages. The stage rotates around the optical axis, and also around its own axis, by means of a milled-head pinion, enabling it to be completely inverted, and a graduated circle registers the degrees as it goes round. All the illuminating apparatus, if desired, swings around a centre level with the stage. The obliquity of illumination is registered on a large graduated circle, which is movable up and down, carrying with it all illuminating apparatus. To fix the body in any position a lever-handled clamp is attached to one trunnion. The fine adjustment is retained on the end of the body. If this microscope can be claimed as an instrument of supreme precision, it is wrong to place the fine adjustment on the body. Every time it is moved the magnifying power of the instrument is changed, and an error is introduced, and the microscope is just that much *not* an instrument of precision. Means have been found to remedy that defect, and all possible sources of error should be eliminated from the microscope of the future, just as soon as means are found to do it.

Another large instrument made by Beck, having a stage motion of four inches in either direction, is reported.

Zentmayer's improved "Centennial" stand was shown. Its new mechanical stage, five inches in diameter, is claimed as the thinnest yet made. Light 70° oblique is admitted beneath it. Milled heads move it vertically 1¼ inches, and literally 1¼ inches. It may be inverted, if desired, retaining still the object in the centre of rotation of the sub-stage. The plan of swinging the sub stage is well-known, and not capable of improvement. It is the most simple plan yet devised for that purpose. The fine adjustment moves the entire body without changing its length. The finish and workmanship, and the motions of the instrument, place it, in precision, simplicity and excellence, far ahead of all microscopes at our meeting. Since this microscope appeared at our Centennial Exhibition for the first time, many skillful makers have aimed to secure some of its advantages by ingenious mechanical devices, but none yet have approached its classical simplicity and fewness of parts. This instrument marked a new departure in the construction of microscopes, and without injustice your Committee can say no less.

We report two lamps attached to microscopes in place of the mirrors. One was an ordinary Beck's lamp, fitted with a carrier for the purpose. The other, made by Zentmayer, was three inches high, including chimney of blue glass, and about 1¼ inch wide. It could be adjusted without rack in every direction, gives out no perceptible heat of a hot night, and will burn without refilling for six hours. With Wenham's modified binocular prism it gives superabundant light in both fields, with a twentieth objective. With his ordinary prism, it fills equally well both fields with all lenses up to a fifth. It requires only a slight addition to the ordinary condenser to make it very desirable. It is elegantly made.

Editorial Department.

Periscope.

Non-Interference in the First Stage of Labor.

Dr. G. Hamilton, in an article on obstetrics, published in the Edinburgh *Medical Journal* for October, 1880, remarks:—

On a former occasion I said that it seemed to me almost worthy to be held as axiomatic that, in labor, danger to the mother will increase in the ratio in which the forceps have to be, or rather are, introduced *within* the uterus, even when the os is well dilated; and this was very forcibly brought out during the recent discussion on the subject in the London Obstetrical Society. In the *Medical Times and Gazette* for August, 1879, it is remarked by the editor that when the practice at the Rotunda of Collins (who used the forceps only once in 608 deliveries) is compared with Johnston's, who (often before the os was dilated) used them once in ten deliveries, the maternal mortality has been

more than doubled, while the fœtal mortality was also increased. On these statistics I would make two remarks: 1st, as I have said already, there may be great fallacy in comparing maternal mortalities at all, from the erratic outbreaks of puerperal fever; and 2d, in this case I would say we are only comparing one bad practice with another bad one, which at most can give us only very unsatisfactory results. The discussion, however, has been a most valuable one, and the tendencies have mostly, I think, been in the right direction. It is to be hoped that it will, at any rate in this country, give the *coup de grace* to frequent instrumental interference with labor in its first stage, though I almost got afraid for a time that Dr. Johnston's high position and example were going to make it "fashionable." Whether it survive in this country or not, however, it does not yet seem dead in "the States," for, through the politeness of Professor Taylor, of New York, I have lately received from him a reprint from the 4th vol. of the *New York Gynecological Transactions*, in which the same practice is still advocated, and in which a drawing is given of forceps 16 inches long and with blades only 1½ inch broad, which can, the Professor states, be introduced through a very small os uteri. Of this practice I have no experience and as at present I am using my pen chiefly for the benefit of the younger members of the profession, I think I need say nothing further regarding it, as all confess, at least, that the practice is a difficult one. My forceps are 13¾ inches long and the blade 1¾ inches broad, and I have always as yet found them to answer the purpose required most admirably. They are straight, and I therefore never get confused in thinking of possible injuries to the mother; and when the head is at the brim I throw the handles back toward the perineum, to enable me to lay hold of it; in doing this I am not particular in what direction the instrument catches the child, for I have never known my forceps injurious, even when placed over the face. When they do catch I use gentle traction with one hand, at the same time that I push the uterus up over the head with the other, until I am able to touch an ear, and then I usually find that all is simple and safe.

The Treatment of Nephritic Colic.

Dr. C. G. Stockton, himself a sufferer, says on this subject, in the Buffalo *Medical and Surgical Journal*, Nov., 1880:—

Sydenham enthusiastically advocates the use of beer "To cool off the ardent humors that remain in the kidneys and produce stone." Segalas and more recent writers reinforce this statement. I found that beer aggravated these symptoms, as did sour wine and cider. Most writers pronounce beer and all fermented drinks injurious. Sydenham having experienced personal benefit from the frequent use of cathartics, recommends the use of manna and lemon juice. (This acted unfavorably in my own case, where the stone was oxalate of lime.)

But diluents, recommended by the most ancient of medical authorities, still best subserve our purpose at this time. So much for a condition of comparative repose. It is after some unusual exertion that a sensation of uneasiness and qualmishness is experienced, followed soon by intense pain in the lumbar and inguinal regions of the affected side; this shoots down into the corresponding testicle, which alone, or with its fellow, is violently retracted. Micturition is painful and almost continuous, the urine scanty, highly acid, of a grayish hue and mingled with blood. The gastric apparatus is greatly disturbed; there is flatulence, colic, frequent dejections, tenesmus.

The pain is best controlled by morphia and atropia, hypodermically, and the application of heat, either by long continued general bath, or by rubber hot-water bags placed under the back and about the scrotum. I cannot speak too highly of the hot-water bag as an epithem. It is more efficacious than the bath, since it can be used continuously without fatigue to the patient.

Enormous eating should be proscribed; the meals should be small, frequently and regularly taken. Hard, particularly lime waters, should be interdicted; but the drinking in abundance of wholesome waters advised.

Upon drinking Niagara water I find the urine more acid and turbid. Drinking Bethesda, Apollinaris, or rain waters, increases and clears the urine, rendering it less acid. This is especially true of Bethesda water.

The Gettysburg Katalsyne is an agreeable water, and has a favorable reputation as a remedy in renal concretions, as its constituents would lead us to suppose.

Probably the springs of Vichy provide the best waters for cases of the uric acid diathesis.

The Celestine spring is most frequented by patients with gravel, though without any apparent reason, as the spring is less alkaline than its fellows.

The Malvern water is a favorite in England. It is almost perfectly pure; so far as I know, the purest spring water on record. There is no end of good waters. I have for some time been drinking "Rosicrucian springs" water; it comes from Maine, is very agreeable, and is said to be like Apollinaris without the gas.

On the Therapeutics of Chronic Metritis.

M. Gallard, in *Le Concours Médical*, October 9th, 1880, discountenances active antiphlogistic treatment; for, succeeding the primary hypervascularization of the uterine tissues, there ensues a period of anæmia with general atrophy of the vessels of the organ.

He recommends simple emollient baths, particularly at menstrual periods, or when there is any recrudescence of inflammatory action. Alteratives would seem peculiarly indicated in a disease characterized by a deposition of plastic material determining the augmentation in volume of the organ, but they generally induce, when long used, so much derangement of the general health, that the small amelioration obtainable from them does not often justify their use for any considerable period of time.

Tartar emetic has been used in large, even Rasorian doses, in puerperal metritis, with doubtful benefit.

Calomel, which is frequently given, generally

induces salivation too early, which is also the case with blue pill; bichloride of mercury with conium, as recommended by West, can be administered for a longer period.

When, in the first stage, there is peritoneal inflammation, mercurial ointment spread over the abdomen is of benefit; and M. Gallard often uses the diluted ointment to dress blisters, applied over the abdomen in later stages.

The preparations of iodine have had such a favorable action on the indurated tissues, particularly when dysmenorrhœa or amenorrhœa was present, that some of the salts of the iodides of iron and of potash have been considered emmenagogue. Ergot is of undoubted benefit in the first stage of chronic metritis, where the uterus is gorged with blood; by inducing contractions it improves the tonicity of the organ, the circulation becomes more rapid, the exudation products ready to be transformed into laminated interstitial tissue are absorbed; in fact, the inflammation is often subdued before arriving at the second period. Ergot may be given in powder, gr. ss.-j, ter in die, or in pill, as in the following formula:—

℞. Ergotin,
Ferri carb., āā ʒj–gr. xv
Ext. opii, gr. iv.

Form the mass into fifty pills, of which four may be taken daily; if abdominal pain should be complained of, the use of ergotine should be dropped for a period.

Effects of Lightning-Stroke on the Animal Organism.

Professor Nothnagel relates (Virchow's *Archiv*, May, 1880) some experiments he made on rabbits with the Leyden jar. He found that sufficiently powerful sparks produced a localized anæsthesia of transient nature. The extent of the lesion was proportional to the density of the electrical fluid, that is, to its quantity divided by the diameter of the limb. At the same time the motor fibres were temporarily paralyzed, the duration of the paralysis being about the same as that of the loss of sensation. The faradic excitability of the paralyzed nerves was diminished. The author next describes a case where a man was struck by lightning on his right hand, which became completely paralyzed and anæsthetic, and remained so for ten weeks. The recovery was sudden and rapid; in two days the hand became quite well again, and remained so for six years, when suddenly both sensation and motion disappeared from it. Three months after this occurrence he was admitted into the hospital. He was submitted to the usual electro-therapeutic measures during a few days, but without the slightest benefit. One day, however, it occurred to Professor Nothnagel, who was then experimenting with the magnet on a case of hemi-anæsthesia, to apply the latter to the paralyzed hand. His astonishment was great on finding that within three-quarters of an hour sensation and motility were returning. Further applications of the magnet were followed by a complete recovery, and a few days afterwards the patient resumed his work. No transfer was observed.

Chrysophanic Acid and Pilocarpine in Skin Diseases.

The St. Louis *Courier of Medicine and Collateral Sciences*, for October, informs us that at the meeting of the St. Louis Medico-Chirurgical Faculty, July 12th, 1880, Dr. Hardaway remarked—

The members present will probably recall to mind a case of psoriasis occurring in a boy of thirteen, whom I exhibited to the Society some months ago. At that time the eruption had disappeared after a few weeks of treatment by an ointment of chrysophanic acid. He took no constitutional treatment. When seen a few months ago there had been no return of the eruption. This case is not brought forward to prove that relapses do not occur after the use of chrysophanic acid, for a considerable experience with this drug in this disease demonstrates the contrary; but I mention it merely as exhibiting the now acknowledged remarkable influence of the remedy, and principally to show that local treatment is all sufficient for the relief of psoriasis, and that the recurrence of the eruption is not any more to be expected than after the most carefully conducted general medication. In a case recently treated, occurring in a gentleman of about forty years, who had been affected from youth, the eruption was unusually inveterate, and required, for some patches, an unusual strength of ointment—ninety grains to the ounce—for its removal. Usually a ten or twenty per cent. ointment is sufficient. While on this subject I may mention some recent experiences with the muriate of pilocarpine in skin diseases. I have given the drug in a number of cases of alopecia, but as yet with no definite results. In an exceedingly obstinate case of general pruritus, after I had run through the usual list of local and internal remedies without avail, I placed my patient on one-eighth grain doses of pilocarpine, as advised by Pick. This quantity proving of no service, I increased it to one-quarter grain twice a day. The former dose had not produced the physiological effects of the drug; but one-quarter grain caused profuse perspiration, with but little salivation, and very soon after this effect was noted the pruritus disappeared.

Sudden Death in Typhoid Fever.

The *Lancet*, October 2, observes: The occurrence of sudden death in typhoid fever, without any hemorrhage or perforation to explain it, has been variously accounted for. According to Dieulafoy it is always due to syncope, a reflex result of the intestinal lesion. But the accident has been met with after the intestinal ulceration has cicatrized, and also in typhus, in which there is no ulceration of the intestine. Hayem has ascribed it to organic changes in the heart, degeneration of the muscular fibres, but in some cases described the heart has been found to be healthy. Laveran attributed it to cerebral anæmia, and Huchard to a combination of this with cardiac degeneration. M. A. Marvaud has re-examined the question in the light of some cases which occurred last winter at Algiers. In this epidemic, thoracic complications were especially frequent. Twenty-two cases died out of ninety treated at one hospital, and in ten of these the

heart presented ante-mortem clots. In four of these ten cases death was sudden; in three there was slow asphyxia with collapse, and in one death was preceded by free intestinal hemorrhage. In the four cases of sudden death this occurred while the patients were making an effort. M. Marvaud believes that the pulmonary complications may have assisted in the production of the intra-cardiac coagula—first, by the mechanical obstruction to the circulation, and secondly, by increasing the tendency of the blood to coagulate. In some cases death is instantaneous, and probably in these the intra-cardiac coagula interfere with the action of the valves, or plug the pulmonary artery. In other cases death follows asphyxial symptoms—quick breathing, anxiety, oppression, cyanosis, chilling of the extremities, small pulse, and collapse.

Venesection in the Treatment of Hæmophila.

Mr. Henry Finch reports the following case in the *Lancet*, Oct. 2, 1880:—

A stout, healthy lady, between fifty and sixty years of age, was suddenly attacked in bed, at night, with profuse bleeding from the nose. I was sent for, and the patient, whose indomitable pluck and steady coolness under a full knowledge of the danger she was incurring contributed much to the fortunate issue, told me that a brother had died in a few days, from uncontrolable bleeding following some very trivial skin wound, and that an aunt had frequently suffered from copious bleeding consequent on very inadequate exciting causes.

The patient was treated in the routine manner—astringents syringed into the nasal fossæ, ice, iron, and ammonia internally, and finally plugging the nares; but all to no purpose. The bleeding, if it ceased for a time, soon came on with redoubled energy; the patient at intervals vomited quantities of dark blood.

I was with the patient two nights, who, notwithstanding the increasing pallor, anæmia, and weakness, preserved her spirits wonderfully. After forty-eight hours of this continuous bleeding, it was evident that unless the hemorrhage could be stayed death would speedily ensue, and as a last resource, in a sort of empirical way, we determined to try the effect of diminishing the blood-pressure by opening a vein in the arm. The state of the patient, while it nerved us to adopt any probable means of staying the flow, made recourse to this particular remedy without previous experience an anxious proceeding. Mr. Sloman opened a vein in the bend of the left arm with some difficulty, owing partly to its small size, and partly to the presence of much superficial fat. The nasal bleeding stopped as soon as a little dark blood had flowed away. After making sure that no further loss was taking place, the vein was closed. The hemorrhage did not return, and from thence forward the patient made a protracted but perfect recovery.

In two other cases which I can call to mind—a gentleman of thirty and a girl of seventeen years, both with well-marked hemorrhagic diathesis, and with hereditary history of the complaint—I have tried venesection, and in both cases success has been immediate and complete.

The Approximate Estimation of the Size of a Stone in the Bladder.

Dr. W. Huston Ford, of St. Louis, Mo., in an article on the "Early Diagnosis of Stone in the Bladder," published in the St. Louis *Medical and Surgical Journal*, says:—

To estimate the size of the stone after fairly striking it, the sound should be introduced far enough to make sure that its tip has passed beyond the calculus, care being taken to avoid touching the stone in doing so. The instrument is now to be very gradually and slowly withdrawn with light taps on either side as before, until the stone be grazed, when the clip upon its shaft is to be slidden up to the extremity of the penis and its position on the shaft, read off. The motion of the sound must be always steadily outward, so that the penis is stretched and its extremity thus made available as a fixed point for measurement. The clip being fixed, the sound, after grazing the distal end of the stone, is still cautiously withdrawn with light taps upon the stone itself until these cease to be heard, when the slip is again run up to the meatus and a second reading made. The difference between the two readings will be the diameter of the stone, *approximately*, in the direction in which it lay when struck. A still more accurate estimate can, of course be had, by direct measurement between the jaws of a light lithotrite designed for that use, but this instrument forms a part of the armamentarium only of operating surgeons.

Fuchsin in Bright's Disease.

In Virchow's *Archiv*, Bd. 80, Prof. De Renzi, of Genoa, gives his experiments on Bright's disease. He arrived at the following conclusions: 1. When chronic Bright's disease is left entirely without treatment, in general no improvement is shown; hence this must be excluded from the category of those diseases which in many cases end in spontaneous recovery. In the first days after entering the hospital, or when the treatment is purposely left off, the patients show a considerable quantity of albumen; this rule has, however, some exceptions which have not up to the present time been well explained. 2. Fuchsin, which has lately been recommended in the treatment of Bright's disease, produces a remarkable diminution in the quantity of albumen. It was employed in two forms: dissolved in water, or, mixed with a suitable extract, in pills of 2½ centigrams each. As, however, the strong coloration of the infusion of fuchsin in water is somewhat repulsive, Dr. De Renzi found it preferable to administer it in the pill form, and to this he has adhered in his latest prescriptions. 3. The daily dose of fuchsin may be much greater than that in which it has hitherto been recommended in the treatment of Bright's disease. Dr. De Renzi generally began with a very small dose of 5 centigrams (0.75 grain), raising it to 25 centigrams (3.8 grain), to be taken in twenty-four hours. A considerable physiological action on the principal functions of the body was observed. According to the dose of fuchsin, the urine began sooner or later to show a red color, which maintained itself

throughout the treatment. 4. The urine in Bright's disease often exhibits a great deal of mucus. Fuchsin is very useful against this complication, as, in a short time, it causes the complete disappearance of the mucus from the urine. 5. The mucous membrane of the digestive track is deeply colored by fuchsin, and the blood-plasma undergoes considerable coloration. In two cases, the quantity of hæmoglobin and the chromometric state of the blood were examined with Bizzozero's instrument, with the following results: *Maria Molinari:* Cytometric state, 160; Hæmoglobin, 68.7; Chromometric state, 175. *Theresia Gabella:* Cytometric state, 115; Hæmoglobin, 29.7; Chromometric state, 112. It is evident that the increased intensity of color is not to be ascribed to the increase of hæmoglobin, but rather to the increase of the fuchsin in the blood. 6. When fuchsin does not pass into the urine, this is an indication of an organic disturbance which must not be neglected. In these cases, it is of no use in the treatment of albuminuria. 7. Rest of the patient in bed is a very important means of diminishing the albuminuria in Bright's disease. In a patient, *Vittoria Rossi*, complete rest in bed, together with milk-diet, brought about the greatest diminution of the albumen in the urine. Dr. De Renzi was several times able to ascertain that unusually active movement of the person had a dangerous effect in Bright's disease. 8. Apomorphia was in general well tolerated; and Dr. De Renzi has ordered it in larger doses than usual (viz., 5 to 6 centigrams daily) without causing the least disturbance. In one case, this medicine considerably improved the condition of the patient.

The Use of Chloral as an Anæsthetic in the Minor Operations on Children.

M. Bouchut has written to the *Gazette des Hôpitaux*, on an anæsthetic he employs in the minor operations on children. The agent he uses is chloral, of which he administers one, two, three, and four grams, according to the age; two grams might be given without danger, between three and five years. The dose, one, two, or three grams, as the case may be, is given in four ounces of water, well sweetened; the whole being taken at once. Half an hour afterwards the child sleeps, and in an hour is perfectly insensible. This sleep lasts from three to six hours, and the child awakens as fresh as if after natural sleep. Once insensibility arrives a great number of operations can be performed, such as extraction of teeth, destruction of erectile tumors by caustics, application of Vienna paste, opening of abscesses, thoracentesis, redressing of malformed limbs, anchylosis, etc., without any other inconvenience than that of leaving the children to sleep off the effects of the chloral. M. Bouchut asserts that he has administered this anæsthetic over ten thousand times at the hospital (*Hôpital des Enfantes Malades*), and never had an accident; where the stomach rejects the chloral (which is very rare in children), a suppository with the required dose is given, and when it has melted sleep comes on. M. Bouchut, however, is not much in favor of this mode, as chloral, he has found, irritates the rectum after the third or fourth time. Although chloral is so well tolerated in the child, it is far from it in the adult. M. Bouchut never could succeed in giving a dose large enough to produce insensibility, as when four grams were administered it was rejected at once. If the employment of this anæsthetic, says M. Bouchut, were attended with any danger, it should be abandoned, but as I have already stated, there is none whatever.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the Archives of Laryngology, Vol. I, No. 3, 1880, contains a paper "On the Use of the Thermo-cautery in Tracheotomy," by Dr. J. Böckel, of Strasburg, translated by Dr. C. E. Sajous, of Philadelphia.

——The "Surgical Treatment of Naso-Pharyngeal Catarrh" is the subject of a paper which was read before the American Medical Association by Dr. D. H. Goodwille, and which now comes to us in pamphlet form, reprinted from the *Medical Gazette*, July 31, 1880.

——We have received in pamphlet form the address delivered before the Medical Society of the State of Pennsylvania by Andrew Nebinger, M. D., President of the Society, at its annual meeting held at Altoona, May, 1880. The chief subjects discussed were "Medicine and Medical Education."

——Dr. Geo. J. Engelmann, of St. Louis, Mo., in a reprint from the Transactions of the Missouri State Medical Society, 1880, discusses the "Dangers Incident to the Simplest Uterine Manipulations and Operations," giving the history of twenty-three cases. The same author also sends us a supplement to his recent paper on "Time of Conception and Duration of Pregnancy," in which three additional cases are recorded.

——There has appeared, in pamphlet form, a very interesting letter addressed to Rear-Admiral Daniel Ammen, U. S. N., on the "Inter-oceanic Ship Canal and the Yellow Fever Zone," by John Gamgee, in which the author advocates the opening of communication through the Nicaragua Lake, as vessels in crossing the Atlantic would reach this sooner, and not be becalmed in the equatorial Atlantic, where the author asserts that yellow fever originates. Those interested in the medical aspect of the inter-oceanic canal should not fail to read this letter, as well as Dr. Boyland's masterly paper, before alluded to in the Reporter.

BOOK NOTICES.

—

Report on Yellow Fever in U. S. Steamer Plymouth. Extracted from the Report of the Surgeon-General of the Navy, 1880.

In the Hygienic and Medical Reports of the Navy Department for 1879, Surgeon Theoron Woolverton gave an account of yellow fever on board the steamship Plymouth, which not only redounded to the reporter's credit, but to that of naval surgeons as a class. It is to be regretted that the excellent opportunities enjoyed and sound sense so often displayed by our naval surgeons have been imperfectly appreciated by students of yellow fever. Case after case has been recorded and made the subject of special inquiries, with the most frequent result of demonstrating dangerous forms of naval decay and rottenness which, in tropical cruises, have combined with the essential marine factor for the development of this plague. In his statement, Surgeon Woolverton said: "It is my conviction, from the course of the disease, that the yellow fever infection is confined to the hull of the ship, and especially in the rotten wood about the berth deck." It will be remembered that the Plymouth was frozen out, but much of the badly decayed wood was left in her, notwithstanding some considerable repairs at the Boston Navy Yard, prior to sailing for the Windward Islands, last year. No sooner was the vessel subjected to tropical heat than yellow fever recurred, and the cruise had to be abandoned. Surgeon Woolverton declared that it was "not shown that cold will not destroy the yellow fever infection, but only that cold did not sufficiently or entirely penetrate the spongy wood to reach it."

With commendable solicitude, the Secretary of the Navy has pursued this case to the end, and Surgeon-General Wales has done wisely to exhaust all means of research within his reach. The monograph before us is full of interesting and suggestive matter. It shows how gradual, and yet not slow, was the deterioration in the Plymouth's sanitary condition. Launched at midsummer, 1868, and extensively repaired in 1873, she was peculiar for having an excess of white oak over live oak in her hull, and in 1877 "she began to show herself to be a decidedly unhealthy ship." In the fall of 1869 she suffered from yellow fever, notwithstanding stringent precautions against the introduction of the disease. In a report made at Hampton Roads, November 17, 1878, Surgeon Woolverton gave it as his opinion "that the fever had a purely local origin in the ship."

It was the second outbreak, on the brief cruise of 1879, after a winter's frost, that staggered naval officers and the public at large. The board over which Medical Inspector R. C. Dean presided has dispelled the mystery, while fully sustaining the mature opinion of the steamer's own surgeon. Surgeon-General Wales ordered a thorough inspection, by exposing all parts of the ship to view, and confined spaces, whence openings gave exit to a very offensive odor, were discovered. The ceiling and hanging knees, clamps, etc., were extensively decayed all along the berth deck. Fungus abounded. Behind the locker on the port side was found a large quantity of partially decomposed refuse. Fœtor was unlocked, especially above "the port and bunker, and here four cases of yellow fever, all occurring during the first outbreak, were billeted. One case, occurring during the second outbreak, was billeted on the starboard side, exactly opposite, and one near the galley — localities where decayed wood was found to be particularly abundant."

Omitting various data of a like description, it is interesting to read, that "on the starboard side one of these spaces were found to be completely filled with a soft mass, of intolerably offensive odor, which seemed to consist chiefly of beans in all stages of decay; the other space was equally full of sponge, clothing, chips, and other refuse, more or less decomposed. The stench from these deposits was such as to drive the workmen on deck."

"Between other frames, on both sides, were masses of bacterial growth similar to that found in the forward shell room; and on the port side, in the *culs de sac* corresponding to those containing the beans and refuse on the starboard side, were found a quantity of unrecognizable decomposing organic matter. *It was directly above this hold that three cases of yellow fever occurred during the first outbreak.*

"Under the flooring of the magazines was a great accumulation of decomposing chips and auger dust, emitting a foul odor, and evidently left there when the ship was built. Under the lead-lining the sheathing was entirely rotten and blackened, as if the wood had been charred, and in this rotten wood dead rats and their nests were found. The thick strakes and ceiling were badly decayed. On cutting through the bread-room floors, confined air of offensive odor escaped. Living and active flies crawled out of confined spaces between the floors.

"We are of opinion," says the board, "that the various deposits of decomposing organic

matter, and the quantity of decayed wood above described are closely connected with the development of yellow fever on board of the Plymouth."

The narrative as published is most instructive, and we regret that we cannot follow the reporters in their speculations as to disinfection and the germ theory. The germ is still undiscovered, if there be any; its discovery cannot, in our opinion, upset the truth that low temperature is destructive of the yellow fever poison. That is the one incontrovertible fact in the history of the disease; but no sane man would pretend permanently to purify a foul ship like the Plymouth, without first removing all fetid accumulations and rotten wood. The attention of naval constructors should again be directed to the dangers of wood shavings and to the inconvenience of inaccessible recesses which may accidentally be filled by putrescible substances. Neither sulphurous acid nor frost could neutralize the mass of putrefaction which, in the yellow fever area, might have destroyed the ship's company, but for Surgeon Woolverton's prompt diagnosis. G.

On the Bile, Jaundice, and Bilious Diseases. By J. Wickham Legg, Fellow of the Royal College of Physicians, of London, Assistant Physician to St. Bartholomew's Hospital, and Lecturer on Pathological Anatomy in the Medical School. New York, D. Appleton & Co., 1, 3 and 5 Bond Street, 1880. Cloth, 8vo, pp. 719.

The first four chapters of this work are devoted to the chemistry of the bile, the bile acids, bile pigments, the fats, salts, gases, and other constituents of the bile, and the physical and chemical appearances of human bile. The history of the physiology of the bile, and the sources of bile in the economy, the amount of bile secreted in health and the agents which affect it, the office of the bile and the action of drugs upon its secretion, form the subjects of the next four chapters. A chapter is then devoted to the physiological action of bile, after which comes a thorough discussion of jaundice, its etymology, history and etiology, symptoms, complications, morbid anatomy, diagnosis, prognosis and treatment, different varieties, etc. Yellow atrophy of the liver, yellow fever and poisonings by phosphorus, arsenic, antimony, and other substances producing a jaundiced condition, are next taken up for consideration. Icterus febrilis, i. syphiliticus, i. a venenis, i. gravidarum, i. embryonum, i. neonatorum, i. infantum, with congenital defect of the gall ducts, and i. menstrualis, all receive their full attention. A chapter is then devoted to *bilious diseases*, a term which the author very sensibly suggests should be discontinued, as it is incorrect, and apt to confuse and mislead rather than give information, the diseases included under the term being now commonly attributed to acute gastro-intestinal catarrh, and the jaundice which sometimes accompanies them being purely accidental. The last chapter contains a complete bibliography of icterus epidemicus, acute yellow atrophy of the liver, and congenital constriction of the gall ducts. As will be seen, the work is almost encyclopædic in its character, the author giving not only the results of his own researches, but also the opinions of the leading authors from the earliest period in medical history down to the present day. New light is thrown upon the rational treatment of hepatic disorders, and the universal use, or rather abuse, of cholagogues condemned. The author in his preface deplores the fact that in England all experiments on animals have been forbidden, which rendered it necessary for him to cross over to France in order to carry out his investigations. Says he: "We pay for our freedom in some matters by being at the mercy of every truculent agitation in others; and a senseless outcry by putting on the garb of religion and morality from the highest authorities in which it receives no countenance, but rather condemnation, has prospered in its design for a time."

On Slight Ailments: Their Nature and Treatment. By Lionel S. Beale, M.B., F.R.S., Fellow of the Royal College of Physicians; Professor of the Principles and Practice of Medicine, King's College, London, etc., etc. Philadelphia, Presley Blakiston, 1012 Walnut Street, 1880. Cloth, small 8vo, pp. 353. Price $1 50.

This work has been prepared from a series of lectures delivered by the author in the autumn of 1878, and contains a large amount of valuable information with regard to the nature and management of such minor troubles, which though not dependent on any demonstrable organic lesion, are still apt to give the patient a great amount of discomfort and anxiety, and perhaps to puzzle the physician far more than the gravest disease. Prof. Beale is so well known as a scientific writer, that a work from his pen is sure to be welcomed by those who have read any of his previous productions. His style is so clear and interesting, and in the book before us the symptoms and course of the diseases treated of are so vividly and accurately depicted, and the advice given as to treatment so excellent, that no student or young practitioner should neglect to read it.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA

TRICHINOSIS AND ITS SEQUELÆ.

Not long since we called attention to the fact that American pork had been forbidden entrance into a number of European countries, on account of its alleged infection with trichinæ. At the same time we urged the appointment of inspectors to examine all swine slaughtered for the market. For years this has been done in Germany, and in that country no one is allowed to kill a hog without notifying the inspector to examine the flesh.

The subject of trichinosis has received more attention in Germany than elsewhere, simply because the disease is more prevalent there; and the reason of this is that the Germans consume their meat very frequently in a raw or half cooked state. One of the latest studies of this subject is by Dr. RUPPRECHT, in the *Vierteljahrsschrift für Ger. Med.*, October. His results are so interesting that they merit repeating.

He finds that this parasite causes in the human subject quite different symptoms, depending upon the number present in the body. His estimate is that when there are in round numbers 30,000,000 present, there is a choleroid form of disease which makes its appearance at the end of the second week, beginning with diarrhœa and vomiting. The result of this is generally fatal. A second form occurs, bearing strong resemblance to typhoid fever. In this at least 20,000,000 of trichinæ are present. It arises after the consumption of half cooked meat, as the choleroid form follows the use of quite raw flesh. In both cases death results from paralysis of the muscles of respiration, or else from intercurrent pneumonia. In case the sickness does not appear until from twenty-one to twenty-four days, there are, as a rule, only 5,000,000 or 10,000,000 present, and then the sickness has rather the appearance of acute rheumatism of the joints. When not more than a million trichinæ are present the malady begins about the twenty-eighth day after the use of under-done meat, and has a course similar to wandering rheumatism, and is without immediate danger.

The great variety of the symptoms and the varying time they appear after partaking of the infected food make it very probable that numerous cases of trichinosis occur without being recognized by the physician. Who can say how frequently a false diagnosis has been made? Certain it is that unless the attention is especially directed to the subject they will surely pass unobserved.

Hardly less serious than the disease itself, are its possible sequelæ suggested by Dr. RUPPRECHT. These include not only prolonged muscular pains simulating rheumatism and permanent muscular irritation, but also apoplexy. The latter arises from embolia which gradually form from softening of the tissues, the result of irritation caused by the trichinæ capsules. He thinks he has observed this and traced the attack of trichinosis.

But this is not the worst. He claims that the slight but constant irritation of the muscles, arising from the presence of the parasite, may in the end develop *cancer!* At any rate, he says there have been found, many times, muscle penetrated with trichinæ in the immediate vi-

cinity of cancerous tumors. It would take considerable evidence to persuade us to go this far, but the assertion is worth repeating.

It will be asked whether the writer quoted offers any information as to treatment. Very little. He tells us we must look to the future. He mentions benzine and ergot, with which we have long been acquainted, and of which we know little that is good. A new suggestion of his is *gall*, which in one case appeared to destroy the parasite, or at least none could be found after its exhibition.

Meanwhile he recommends as the soundest plan to proceed, to begin with an emetic, follow it with a fifteen-grain dose of calomel, and this to be backed up with quinine and iron. The difficulty is to preserve life during the unconquerable aversion to food which overcomes the patients in severe cases.

As to prevention, his recommendations are, conscientious, scientific inspection of the flesh of all swine, and its thorough cooking when prepared for food; unless, indeed, we are willing to obey the command so positively laid down in the Bible, and refrain from eating swine's flesh altogether.

As few can be persuaded to do this, the other alternatives deserve the more attentive consideration.

THE VALUE OF DIPLOMAS.

The recent exposures on the subject of the diploma traffic, made in this city, have led to a general discussion as to the value of these supposed evidences of learning. One of these discussions appeared in the London *Times*. That important organ of public opinion intimates that bogus diplomas are nearly as good as any others; and that the title of M.D. might well be abolished, leaving to every one the right to call himself doctor who follows the indicated profession. Commenting upon the prosecution of Dr. Buchanan, for forging medical diplomas, it says the English universities have sinned quite as much as he, in making degrees a mere matter of money. Many thousands of men add M.A., D.D., or D.C.L. to their names without having answered a question, or shown any scholarship or knowledge over and above what was implied in a B.A. degree. The *Times* considers that Dr. Buchanan was only following out the general contempt for the value of learned titles which exists everywhere.

That this cynical view of the question is partially justified, is shown from an article in the London *Lancet*, of September 25th, which throws some light on the way degrees are given in England. It is there stated that there exists great inequality in the examinations. It is added that many cases of gross ignorance pass licensing boards. Even Sir James Paget had to confess that the examination in his own college was most indefensibly defective. Thus, a person may practice medicine with authority anywhere in the British Empire without undergoing an examination either in chemistry, midwifery, materia medica, or the practice of medicine! Such persons are called surgeons, but are entitled to attend all cases.

We shall not make any remarks on the amount of knowledge required in most American colleges, nor estimate the exact value in erudition of the average graduate. That subject has been often enough discussed of late. Sufficient to say that no one will be bold enough to claim that most American diplomas guarantee even a moderate thoroughness in medical training.

Even in Germany, to which country we are accustomed to look for all that is solid in education, the complaint is frequent that medical botchwork prevails to an alarming extent. In fact, it was in that country that the enterprising Dr. Buchanan opened up one of his most active markets.

How to correct this evil was the subject of a debate at a recent meeting of the German Society of Public Health. We cannot say that any definite results were reached. It seems that at present it is not possible to frame laws insuring higher qualifications in their doctors than the public desire. If they prefer boasting charlatans, ignorant pretenders, or unscientific claimants, they cannot be forced to call in others.

The only suggestion which was made in the

debate referred to worth reporting was, that in every case of death a post-mortem examination should be made by State experts appointed for the purpose, and that unless the pathological appearances verified the cause of death as reported by the attending physician, the latter should be held liable for malpractice. It is easy to be seen that no such step could be taken in this country, and even under the far more rigid rules of German life it was looked upon as impracticable.

For ourselves, we believe that the true solution of the problem rests in the general education of the masses. When they learn what science is, and what the results of correct thinking are, they will require a more and more solid education in medical men, and this demand will, as is usual, bring about the supply.

Notes and Comments.

A New Classification of Skin Diseases.

One of the recent Vienna medical publications is Prof. Ausspitz's "System of Skin Diseases." From a review of it in a foreign exchange, we extract the classification he adopts. It is as follows:—

1. Simple inflammations of the skin variously produced (*e. g.*, eczema, scabies, and acne are in this class).

2. Angio-neurotic dermatoses — dermatoses characterized by extensive disturbance of the vascular tone, with more or less inflammatory congestion on the surface of the skin (*e.g.*, measles, small-pox, medicinal rashes, erythema multiforme, are in this class).

3. Neurotic dermatoses—dermatoses caused by disease of nerves of sensation, and perhaps trophic nerves (*e.g.*, herpes zoster, decubitus acutus, are in this class).

4. Dermatoses caused by passive congestion (*e.g.*, cyanosis, elephantiasis arabum, and scleroderma, are in this class).

5. Hemorrhagic dermatoses (*e.g.*, purpura and scurvy, are in this class).

6. Idio-neuroses of the skin—functional anomalies of the cutaneous nerves, without trophic changes in the skin. (This class contains, among others, neuralgia, pruritus and prurigo.)

7. Epidermidoses—anomalous growths of the epidermis and its appendages (containing, *e.g.*, psoriasis, alopecia areata, hyperidrosis, carcinoma and pemphigus).

8. Chorioblasts—anomalous growths of the corium and of the subcutaneous connective tissue (containing, *e.g.*, lupus, syphiloderma, lipoma, and striæ atrophical cutis).

9. Dermato-mycoses—containing the skin-diseases produced by the vegetable parasites.

This short sketch will suffice to show that Professor Ausspitz's classification is based on a different principle from those with which books on dermatology have made us familiar, and will partially indicate its chief features. The interest of the book lies in the exhaustive criticisms and acute speculations by which the classification is sought to be justified.

The Alkaloid Jaborine.

This is a new alkaloid derived from jaborandi by Drs. Harnach and Meyers, an account of which appears in our chemical exchanges. They state that pilocarpine is in its physiological effects analogous to nicotine, while the effects of jaborine they found to be identical with those of atropine. The separation of jaborine and pilocarpine is based upon their different degrees of solubility in various menstrua, the separation being facilitated by the non-crystallizable property of the jaborine compounds.

The presence of jaborine in commercial pilocarpine was indicated by the action of the latter upon a frog, traces of jaborine causing spasms of the heart. Pure pilocarpine the authors found to contain no jaborine. After having, by means of its physiological effects, determined the presence of jaborine in commercial pilocarpine, the authors set to work to prepare it in at least sufficient quantity to enable them to experiment upon it. The raw materials selected for this purpose consisted in part of jaborandi leaves and partly of the so-called false jaborandi, piper reticulatum, and other kinds of pepper.

Jaborine is a very strong base, differing from pilocarpine by being difficultly soluble in water and easily soluble in ether. Its salts dissolve readily in water and alcohol, and are not crystallizable.

Elephantiasis in the Samoan Islands.

A consular report from Samoa to our government states that the Rev. George W. Turner, M.D., eleven years a missionary at Samoa, has in that time operated on one hundred and forty cases of *elephantiasis* affecting the testicles. In some cases both of the glands were saved; in

others one or both were removed, the latter cases being those where the enlargement was solid. In one instance the organs and parts removed weighed ninety pounds. The disease does not generally interfere with the daily avocations of the patient, unless he is disabled by extensive ulceration, or the occasional attacks of chill and fever which are observed in leprosy. Foreigners may sometimes remain in the islands for many years without being affected, but most of them are attacked within a few months after their arrival. Consumption is not rare, and usually assumes a very rapid form. Venereal diseases are found, but are not prevalent in their worst degrees.

Texas or Splenic Fever.

This disease has been unusually prevalent this autumn in the Western States, and cases have been found near Philadelphia and New York. Several bullocks exported to England have also died with its characteristic symptoms. A conflict of opinion prevails as to whether the flesh of such animals is injurious. It is an important point, which ought to be carefully investigated.

Correspondence.

Cirrhosis of the Liver in an Imbecile Patient Sixteen Years Old.

Ed. Med. and Surg. Reporter:—

Some time ago I assisted at the autopsy of a case that was of interest to me, and hoping it may not be without interest to many of the profession, I send you a report of the case.

On the 24th of last January I was called to Koszta, a neighboring town, in consultation with Dr. Dodd, of that place. After seeing our patient, he asked me to go across the street and see another case that was giving him some trouble. On our way over he gave me the history, which was about as follows:—

Frank F., a strong, muscular lad of sixteen years, mentally little better than an idiot, for some time has had a ravenous appetite; usually eats as much at one meal as an ordinary man will at three, and after suffering an hour or two, will disgorge a gallon or more undigested food. Has a persistent cough and palpitation of the heart. Has had more or less ague all his life.

Found patient lying on a couch complaining of severe pain in the stomach. His brother said he had finished a very large supper about an hour before. Found stomach very greatly distended and tympanitic, crowding the apex of the heart nearly over to the median line, on a level with the fourth interspace, tympanitic stomach reaching as high as the fourth rib and down below umbilicus. He soon vomited a large amount of ingesta, which emitted a sickening odor. This gave him almost complete relief. Now found stomach, heart and lung in place again. Lungs emphysematous, heart enlarged and beating irregularly; spleen perceptibly enlarged.

My diagnosis was dilatation of the stomach, with probable stenosis of the pyloric orifice, emphysema, cardiac hypertrophy and malarial poisoning.

As the patient's imbecility prevented any reform in his diet, I declined to prescribe for him, feeling it would do no good, but requested Dr. Dodd to obtain permission from his friends to allow us to make an examination, in case of his death, which we knew must occur soon. In this he succeeded. On August 22d, seven months after I saw Frank, the Doctor sent me a note, saying he was dead, and requesting me to come up and take charge of the autopsy.

On my arrival the Doctor informed me that about two months before jaundice began to appear, which continued to increase till his death; also complained of pain in right hypochondrium. In a short time general dropsy began to show itself. Soon after an irregular tumor, projecting below the ribs on right side, could be felt. He grew rapidly weaker, and died from exhaustion.

Autopsy 20 hours after death.—Body much emaciated; skin of a dirty yellow-brown color; abdomen distended with gas and small amount of water; slight œdema about ankles; veins perceptible, but not prominent over abdomen. Lungs emphysematous; patches of tuberculous deposit scattered through apex of right. Heart large and fatty; scarcely any muscular structure visible on outside; walls thickened, especially the right side. Liver; the entire organ cirrhosed, presenting the peculiar nodulated appearance; weighed 5½ pounds. Right lobe large and very firmly cirrhosed; left lobe smaller than normal; stomach large and sacculated; capacity of 14 to 16 pints; pyloric orifice just admit passage of lead pencil; walls thickened. Spleen enlarged; weight about 2½ pounds. Left kidney enlarged; right normal. Pancreas small and nodulated, and very broad, presenting an appearance not unlike that of the liver, only nodules smaller and much harder. Did not examine brain.

The most remarkable feature of the case is the existence of cirrhosis of the liver in a lad of his age, 16 years, who had never used any kind of alcoholic drink, never had syphilis, was never troubled with any disease of the liver till two months before his death.

Was it due to continued exposure to malarial poisoning? To his fatty heart, his imbecility, or his dilated stomach? Again, what caused stenosis of pyloric orifice of stomach, that presented no appearance of former ulceration or inflammation.

D. C. Brockman, M. D.

Marengo, Iowa, Nov. 5th, 1880.

Consciousness.

Ed. Med. and Surg. Reporter:—

I have read with much interest Dr. Hurd's courteous note in your journal of Oct. 9th, in response to my communication on the "Evolution of Consciousness." The argument is an old one, but none the less able for that, and upon

purely ethical grounds might, at first glance, seem to be conclusive. Dialectically, the doctor has well spoken, although the deductions from his premises I hold to be unsound, since I cannot admit the truth of the premises themselves. A great and ultimate good must eventually result from this polite interchange of opinion, and from out the darkness we may find our way to the light in an intellectual discussion of the matter. In the beginning, there must have existed amorphous matter. Sentience could hardly evolve itself, unless it be granted that sentient molecules have always been, and were the primary factors of conscious creations. If amorphous matter *did* forerun subsequent sentience, can science bridge over the chasm between that condition of inertness and of sentience? Evolution through successive æons of time may explain forms, and differentiate between them—but how does it account for that vital creative act from amorphous protoplasm to sentience? From amorphous protoplasm, successive grades of amorphous protoplasm may be evolved; but sentience can only be evolved from sentience itself. Again, I hold it to be proven that the form of consciousness which the doctor apportions to lower animals is an automatic obedience to the unalterable impressions of heredity, and which may exist equally in the spinal cord, hind and fore brain. Ducks deprived of their cerebral lobes will swim regularly, though they may never before have been in water. The location of the conscious principle was a matter of considerable concern to Hippocrates, Hierophilus, Democritus, Strabo, Diogenes, Chrysippus, Plato, and Aristotle, and modern thinkers have done but little to elucidate the question.

Horatio A. Bigelow, m. d.
Washington, D. C.

News and Miscellany.

The International Sanitary Conference.

Our readers will no doubt remember that on the 30th of July last a circular was sent by Secretary Evarts to our representatives at foreign courts, proposing an International Sanitary Conference, to meet at Washington, to which the several powers having jurisdiction of ports likely to be infected with yellow fever or cholera were invited to send delegates, properly authorized, for the purpose of securing an international system of notification as to the actual sanitary condition of ports and places under the jurisdiction of such powers, and of vessels sailing therefrom. This resolution had its origin in the practical difficulties which have been encountered in the administration of the regulations and rules recommended by sanitary experience and framed by the legislation of the country, for the purpose of preventing the introduction and spread of yellow fever, cholera, and other contagious or infectious diseases in the territory of the United States, etc.

The date of holding this Conference was suggested to be January 1, 1881.

The following are the propositions which will be submitted to the Conference:—

A. The establishment of a reliable and satisfactory international system of notification as to the existence of contagious and infectious diseases, more especially cholera and yellow fever.

B. The establishment of a uniform and satisfactory system of bills of health, the statements in which shall be trustworthy as to the sanitary condition of the port of departure and as to the condition of the vessel at the time of sailing.

The discussion of these points involves, among others, the following questions:—

I. Who should be the certifying officer or authority as to the sanitary condition of ports and places and of vessels?

II. How can the certifying authority obtain trustworthy information as to the actual sanitary condition of ports and places and as to the presence of contagious and infectious diseases?

III. When yellow fever or cholera exists at or in the vicinity of a port or place, what examination should be made of a vessel sailing therefrom, to secure a trustworthy knowledge of her sanitary condition?

IV. To what extent, and under what conditions, should a clean bill of health be considered as affording satisfactory evidence that the vessel is free from danger of conveying infectious disease?

V. In what way can trustworthy information be obtained from ports or places in countries which have imperfect or unsafe quarantine and sanitary regulations, and which may be unwilling or unable to adhere to the proposed international system?

VI. Whether a schedule of graduated penalties could be fixed, to be exacted from vessels for various offences arising under the proposed international system?

A Healthy Place.

From Flushing, Netherlands, the United States Consul, P. Smith, under date of September 30, writes, that during the months of August and September "a few people died of ordinary sickness," but there was so little sickness that the apothecaries were taking a general vacation, in the absence of business. The military surgeon reports the same healthy condition among the troops in garrison, only seven cases of slight sickness occurring in three weeks, among 760 men.

The Iowa State University.

The Medical Department of the Iowa State University opened with one hundred and eighty students, which is quite an increase over other years. From a calculation made from the catalogues of medical schools for several years, it appears that there are two hundred medical students, on an average, from Iowa, each year. Less than half take a second course or graduate.

Yellow Fever at Key West.

Assistant Surgeon John Y. Porter, United States Army, advises the National Board of Health, under date of November 9th, that from

the 3d to the 8th inst., there had been ten cases of yellow fever and two deaths, at Key West. Similar advices were to-day received by the Marine Hospital Bureau. The latter report states that one of the deaths was Episcopal Clergyman Gilbert, and that one case called pernicious fever resulted fatally on the 10th inst., and, further, that there are some cases occurring outside of the city limits which have not yet been reported.

Items.

—The epizooty in Montreal is increasing in severity, owing to unfavorable weather.

—"Dr." John Buchanan pleaded guilty, in the Court of Quarter Sessions, to two charges of selling an academic degree. Sentence was deferred.

—The New York State Board of Health, at Albany, has adopted resolutions urging the importance of vaccination, to prevent the spread of smallpox. The Board appointed Hon. Erastus Brooks and Dr. Harris delegates to the American Public Health Association, to meet in New Orleans on December 7th.

—The odors of Paris have been worse than ever this summer and autumn. One of the comic papers there represents a country gentleman in the act of inhaling the emanations from a heap of manure. "What are you doing there, papa?" asks the son. "Going into training for a visit to Paris," is the reply.

OBITUARY NOTICES.

ALEXANDER WILCOCKS, M.D., died, Nov. 17th, in this city, of hepatitis. He was born here in 1817, and graduated from Jefferson Medical College in 1844. He had been in delicate health for some years, and traveled extensively for a restoration of strength, with only temporary benefit. His contributions to literature were: Essays on the Tides; Theory of the Two Forces; Reflections Upon the Nature of the Temporary Star of the Year 1572; An Application of the Nebular Hypothesis; Thoughts on the Influence of Ether in the Solar System; its Relations to the Zodiacal Light, Comets, the Seasons, and Periodical Shooting Stars. Also, papers, in the American Examiner, 1845, and American Journal of Medical Science, 1847. He was a member of the Academy of Natural Sciences, Philosophic Society, Historical Society, and Photographic Society. He was very fond of photography at one time, and pursued this study with considerable diligence, as a source of amusement and for his own gratification. He offered his services to attend to the wounded in the battle of Bull Run, and was attached to the medical corps at Fortress Monroe for a time. His health, however, soon broke down, and he was compelled to return to his home.

COPPEDGE.—August 1st, 1880, Dr. C. P. Coppedge, of Wadesboro, North Carolina. Dr. Coppedge had been a practitioner of medicine in Anson county for 33 years, and was a graduate of the Medical Department of the University of the City of New York. At a meeting of the Medical Association of Anson County, resolutions were adopted expressing the regrets of the Society and sympathy with his family.

QUERIES AND REPLIES.

Dr. J. H., of Ohio.—The formula at present used to make Churchill's tincture of Iodine is—

R.	Iodinii,	gr. lxxx.
	Potass. Iodidi.,	ʒ iss
	Alcoholis,	ʒ j M.

Dr. T. H. P., of Pa.—Curaçoa is a liqueur of agreeable flavor, originally manufactured in the colony of that name.

Dr. T. H. F., of Cal.—1. Rubber underwear was recommended by Hebra in some skin diseases. 2. The series of articles you refer to cannot be obtained in the stores here. You might apply directly to the authors.

MARRIAGES.

BELLVILLE—ASH.—At Delaware City, Oct. 27th, by Rev. J. Bellville, D.D., Dr. Frank Bellville and Emma L. Ash, both of Delaware City.

BRANCH—BURBANK.—In Coventry, Vt., Oct. 31st, by Rev. W. C. Somerville, Charles F. Branch, M. D., and Ida H. Burbank, both of Coventry.

BREWSTER—STOUGH.—Oct. 27th, by Rev. E. E. Erskine, D D., Dr. W. C. Brewster and Lolla M. Stough, all of Newville, Pa.

CUTTER—PRINCE.—On Wednesday evening, Nov. 10th, at the residence of the bride's parents, Flatbush, Long Island, by the Rev. C. L. Wells, D.D., Dr. George R. Cutter, of New York City, and Esther J. daughter of John D. Prince, Esq.

HELMAN—ROCKWOOD.—Thursday evening, October 28, at the Fifth Presbyterian Church, by the Rev. A. B. Morey, Dr. C. S. Helman and Miss A. J. Rockwood, all of Cincinnati, O.

HILL—LOUGHRIDGE.—Oct. 20th, by Rev. R. B. Farrar, assisted by Rev. J. Rossell, Dr. T. Benton Hill, of Ruff's Creek, Pa., and Miss Metta W. Loughridge, of Ryerson's Station, Greene Co., Pa.

POWNALL—WALTER.—In Philadelphia, at the St. Cloud Hotel, on Nov. 4th, 1880, in the presence of Mayor Stokley, by Friends' Ceremony, Dr. H. W. Pownall, of Atglen, Chester County, Pa., and H. Louisa Walter, of Christiana, Lancaster County.

STOCKDILL—GOURLEY.—October 21st, 1880, by Rev. J. Horner Kerr, assisted by Rev. W. S. Cummings, at the home of the bride's parents, T. F. Stockdill, M.D., and Miss Nettie Gourley, all of Rural Village, Armstrong Co., Pa.

DEATHS.

COLVIN.—Of diphtheria, in Burlington Vt., Sunday afternoon, Nov. 7th, Dr. Albert Colvin.

DUCK.—In this city, on Friday morning, the 12th inst., at 1933 Chestnut street, C. H. Duck, M.D., in the 62d year of his age.

HODGMAN.—In New York, Nov. 2, Martha Eugenia, wife of Abbot Hodgman, M.D., and daughter of the late Joseph Kean.

SATTERLEE.—At his residence, in New York, Wednesday, Nov. 10, 1880, Richard S. Satterlee, M.D., Brevet Brigadier-General United States Army, in the 82d year of his age.

SEGUIN.—In New York, on Oct. 28th, in the 69th year of his age, Edouard Seguin, M.D.

SHELLY.—On the 9th inst., Elizabeth S., wife of Dr. A. F. Shelly, and daughter of the late Rev. J. A. Strassburger, in her 55th year.

THOMAS.—Suddenly, October 10th, at 10.30 P. M., at his residence, No. 14 West Fourth street, Covington, Ky., of apoplexy, Dr. Charles F. Thomas, in the 59th year of his age.

WILCOCKS.—In Philadelphia, on Nov. 10th, Alexander Wilcocks, M.D., in his 64th year.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1239.] PHILADELPHIA, NOVEMBER 27, 1880. [Vol. XLIII.—No. 22.

Original Department.

Lecture.

THE SUCTION OPERATION FOR CATARACT.

BY R. J. LEVIS, M.D.

REPORTED BY GEO. F. SOUWERS, M.D.

Gentlemen:—I present for your consideration, this morning, the case of A. B., aged about nineteen years, who is, as you see, perfectly blind. She tells us that this trouble did not come on suddenly, but that she noticed for some time a gradual impairment of vision, seeing best not in a bright light, but when the light was somewhat subdued, as at twilight. From the history of the case, and the age of the patient, I can almost assert, without an examination, that she has soft cataract in both eyes. Upon making an examination, I find that in one eye the pupillary space presents a bluish-white appearance, the almost infallible sign of soft cataract; the other eye is rather more opaque in appearance, the result of some operation that has at some time been performed for her relief, but evidently without success. On further examination I discover that in the right eye she has a capsulo-lenticular cataract, while in the left it is simply lenticular in character. I have said before that this was a soft cataract, and you can readily assume that almost any case of cataract occurring before the fortieth or fiftieth year can be classed under this head, for up to this age the lens is itself soft, and has no tendency to become indurated; the difference between the two prominent varieties of cataract may be said to be rather physical than pathological. After the fiftieth year the lens naturally becomes more or less hard, and then we find, of course, that hard cataract is the almost invariable rule. There is another peculiarity distinguishing the two varieties of the disease: the soft cataract is almost always congenital, and in character is nuclear; on the other hand, the hard variety is never congenital, and the opacity is propagated in ray-like lines that mark the original divisions of the lens. We make further subdivisions of cataract also thus, where the lens alone is affected it receives the name of lenticular cataract; if the capsule of the lens is alone involved it is known as capsular cataract; when the two forms amalgamate we have capsulo-lenticular cataract.

The question now presents itself; what shall be done, if anything, to relieve the patient? As a working rule, operations for the relief of this trouble are not performed so long as the patient is able to have any vision at all; when, however, complete blindness has taken place, the time has arrived for procedure. In the case before you, that time has now arrived, and I propose to remove, by operation, the opaque lens from one eye and all that remains of the lens in the other. To accomplish this, I have two methods of procedure to choose between, one known as the needle operation, in which the capsule of the lens is lacerated by the cataract needle, and the removal of the body of the lens accomplished by absorption by the aqueous humor, and another procedure known as the suction operation. This last, I think, is the preferable form; it is more reliable, and considerably less time is consumed in accomplishing a cure.

I hold in my hand an apparatus that has been constructed for this operation; it consists of a piece of rubber tubing about a foot long. To one

end of this is attached a flattened glass mouth-piece. To the other, a piece of glass tubing about four inches in length, terminating in a blunt-pointed silver extremity about an inch in length, this extremity being fenestrated just above its termination. By means of the point of a Beere's knife an incision is made in the cornea just large enough to permit the introduction of the metal tip; at the same time the knife is allowed to make a small incision in the anterior capsule, which may, if necessary, be afterwards somewhat enlarged by means of the cataract needle. A few drops of the aqueous humor immediately exude from the incision, but this does no harm, as it rapidly reforms. The metal point is now inserted into the lens and suction made by means of the mouth, when the cataractous material finds its way up into the glass tube before spoken of. The eye is now dressed by means of the common rubber adhesive plaster, cut in sections to fit the upper eyelids, and these are allowed to remain on for five or six days; they simply act as supports to the lids till the corneal incisions have healed up, a few drops of a two-grain solution of atropia being placed in the eyes before the lids are closed. In order to supply the place of the lens thus removed, the patient is directed to wear, for distant vision, glasses of four and a half inches focal length, and thus she is given, for all practical purposes, a perfectly normal eye.

Communications.

THE PROPER PUTTING TO BED PROPHYLACTIC AGAINST PUERPERAL DISEASES.

BY E. T. BLACKWELL, M.D.,
Of Hackettstown, N. J.

The people among whom I commenced the practice of my profession had, upon the occasion of a birth of a child, many methods very different from those inculcated by our medical teachers. The parturient was dressed for lying-in. Her bed was faultlessly made; but empty. She was often surrounded by women, who attended as "a frolic;" who, when the crisis came, seldom had arranged to prevent the soiling of her clothing, or to have anything in readiness. The first, and a greater part of the second stage was frequently occupied in ceaseless pacing of the chamber, under the idea that labor was promoted thereby; while "the working stage" was passed in the kneeling posture. The position, besides being very awkward and irksome to the practitioner, left the patient, at the end of a protracted labor, nearly worn out, and drippingly filthy; it being nearly impossible to prevent soiling of the under-clothing. At the conclusion of the process, the mother was thought to be too weak to have her garments changed; and therefore she was often placed in bed, wet with perspiration, and soiled by other discharges. Prejudices so rooted could not be dislodged at once; and it was only in the face of appalling dangers that I was able to exert an influence sufficient to break down the ill-starred custom.

In the beginning of the year 1853 a series of desperate cases, three in number, and all fatal, led me most thoroughly to reform the whole lying-in arrangements; to discourage the attendance of an unnecessary number of women; to have the parturient placed in bed, in a mode favorable to cleanliness; and to see to it personally, at the conclusion of the labor, that she was free of moisture; that her bandage secured contraction of the abdomen and uterus; and that her clothing was dry and warm.

The following cases are illustrative:—

Case No. 52. Mrs. H. was delivered by me, December 22d, 1852. I do not remember the condition of her putting to bed. At my visit, on the fourth day thereafter, I was told she was unable to sleep, for which a suitable remedy was given. December 27th I was called at three o'clock in the morning, finding the patient in a fever, for which a potash mixture and Dover's powder were employed. On the following day violent mania ensued, for which, being the first physician to arrive, I practiced venesection, relieving for the time this terrible symptom. Twelve grains of quinia sulphate, and two grains of morphia sulphate were left, to be given in appropriate doses. She was free of the mania for some hours, obtaining some sleep; but the delirium returned, provoked, as I was led to fear, by the injudicious loquacity and questioning of her well-meaning friends. All treatment henceforth was unavailing; death occurred on the fifth day.

Case 54. Mrs. J. B. called me at the end of her period of gestation, December 30th, 1852, to attend her for a severe cold and fever. She fell in labor the day following, and as the process with her was always a most rapid one, the labor was completed, and she was placed in bed before my arrival. A peritoneal fever followed almost immediately, in which quinia, morphia and other appropriate remedies were used. My friend Dr. McLenahan came to my assistance on January 7th. On the 11th she died.

Case 56. Mrs. L. M. was taken suddenly in

labor, January 6th, 1853. She had chosen a remote and unfrequented part of the dwelling for her lying-in. When I arrived a fire just kindled upon the hearth failed to influence the intense coldness of the air. The liquor amnii, just discharged, drenched the bedding and dress of the patient. I do not know what was done to obviate the wetness; but the coldness of the air rendered it impossible to place her in a perfectly good condition. On January 10th I was called to attend her for fever, prescribing calomel, potash mixture and morphia. On the next day she had twenty-four grains quinine, with calisaya extract. On January 14th the consultant in the former case was called, the treatment being continued as before. On the 15th a plaster of cantharides was applied to the abdominal surface, the medicines, with supporting treatment, being continued. Death took place January 18th.

Case 135. Mrs. H. M. was delivered in my absence, on April 7th, 1856. On the day following, peritoneal inflammation being set up, blood was taken from the arm, a blister was applied to the whole abdomen, and suitable anodynes and diaphoretics were given. Antimony was added on the 11th, for which quinia sulphate, ten grains per diem, was substituted, on the 12th. On the 13th calomel was added. April 24th a consultation was had, and the treatment, variously modified to meet changing indications in the bowels, the nervous system, the organs of lactation, and the system at large, was continued. On May 8th and 20th, respectively, an abscess of the mamma was opened, and on May 31st, after an illness protracted to between seven and eight weeks, recovery occurred.

Since the experiences recorded above I have had considerable obstetric practice, with the most satisfactory results. Having given the strictest attention to cleanliness, leaving my patient always dry and warm, and remaining long enough to be secure against the occurrence of hemorrhage, a case of mastitis has rarely occurred; and though there have been occasional cases of peritonitis, there has not been a fatal one since Case 56, January, 1853. The treatment has not differed essentially from that employed in the first cases, except it might be in its increased promptitude, and in greater diligence in detecting early signs of illness. The early use of blisters has seemed to exert a controlling influence; while the other remedies, employed without delay, have given satisfaction. The important point is to extinguish the malady in its incipiency, before a foothold is obtained from which it cannot be dislodged.

Whether the element of contagion should be taken into account, in Case 56, might be worth considering, were it not that the circumstances surrounding that case sufficiently account for its occurrence. While we cannot too carefully guard against this method of disseminating this formidable disorder, I am sure we shall estop the development of many a germ of disease by securing the utmost cleanliness, not alone in our persons, but in the parturient, her clothing, her bed, her chamber, and all her surroundings. Under favorable circumstances, the practitioner being present to enforce proper sanitary regulations, fever or abscess after labor should never occur.

THE "THERAPEUTIC BOOM" AND UNSCIENTIFIC ADVERTISING.

BY F. E. STEWART, PH.G., M.D.,
Of New York City.

I speak in the name of scientific medicine. The other evening I was introduced, by Professor W. H. Pancoast, of Philadelphia, to the Philadelphia County Medical Society, as the originator of the preparation known as desiccated blood. In a subsequent discussion brought about by this fact the following point was developed: To protect the medical profession, it is proposed to discountenance the employment of any new remedy until it is introduced into the Pharmacopœia. Such an introduction can be effected but once in ten years, at which time the Pharmacopœia is revised. I have introduced a new remedy. It has been carefully tested clinically in a number of hospitals, both in New York and Philadelphia, with favorable reports. And now, by the above proposition, its use is to be discouraged until it is admitted to the Pharmacopœia, ten years hence. Against this I most strongly protest.

Now, I do not blame the profession for protecting their interests in every respect, but I question whether the position assumed in this matter be a protection On the contrary, I believe an attempt to carry it out practically can but act prejudicially to the true interests of scientific medicine.

But it is said there are enough drugs already in the Pharmacopœia, and we do not need any additions to the materia medica. It can hardly be argued that the Pharmacopœia is so perfect that it cannot be added to or taken from. Surely, there are drugs in it of such doubtful therapeutic value that they might as well be left out; but are there no new drugs that are

of sufficient value to more properly take their place? If the Pharmacopœia be so perfect, what is the use of revising it every ten years; why revise it at all. Does not the very fact of revision recognize that there is such a thing in science as progress?

But it is said that the "therapeutic boom" is derogatory to any true progress, and should, therefore, be discouraged. That therapeutics is away behind the other branches of scientific medicine and yet in its infancy. The fact that therapeutics is so far behind, would seem to be an argument that it needed "booming," or some other strong stimulant to move it ahead. Not to use any new remedy unless it is in the Pharmacopœia, and to discourage all original investigation for the purpose of discovering new drugs and their action, can hardly help the matter any.

How was it first discovered that any drugs were fit to go into the Pharmacopœia? Have they always been there? Is it not a fact that some of the very best drugs are from the most unscientific sources? Because a drug is used by a quack, an Indian medicine man, or an old woman, is no proof that it is devoid of virtue. By carefully testing drugs in a scientific manner only can their true value be ascertained, and when it is the universal belief by all the old women that certain herbs possess certain virtues, we are just as much justified in trying them, to see if this belief is founded on fact, as were our grandfathers, who collected the best of them to make a Pharmacopœia.

But it is not to discourage original investigation that this stand has been taken upon the part of a certain section of the profession, though that be one of the results. The true reason is for the correction of an abuse. The abuse which these gentlemen wish to correct by it is unscientific advertising. They have become alarmed by the vast amount of misleading advertisements which disgrace the fly-leaves of our medical journals. They see the evil rapidly growing, and propose to stop it. The very fact of the rapid increase of this kind of advertising, and of its misleading character, is abundant proof to them that a great many physicians are being misled by it. It therefore becomes a serious matter, demanding correction. For this reason, then, they discourage the use of all new remedies until they are officially recognized by the United States or other Pharmacopœia.

Now, I do not dispute that the object which is thus aimed at is to be greatly desired, or that by accomplishing it scientific medicine will be benefited thereby, but I do not think the method chosen is a good one. Advertising is legitimate, as long as it tells the truth, the whole truth, and nothing but the truth. It is only when it is misleading that it should be discountenanced. Now, if the profession should take a stand to stop all advertising, and shut down on the use of a single remedy advertised, what would be the result? The result would be this: All the business of a large number of great business houses would come to a stand-still. That is just what the advocates of the new idea under discussion desire. But do they suppose for a moment that all the capital invested, all the stock on hand, all the enterprise and push, all the executive ability and knowledge of methods of creating a demand for goods, would lie idle? What would become of it? Let us see. There is sold in the United States millions of dollars' worth of so-called patent medicines yearly. They are not patented, as a rule, however. The way their sale is controlled, is by notoriety. By this I mean, that though the formula for Helmbold's Buchu is not patented, and never has been, and though that formula is not secret, and is now in my possession, I cannot, nor can any one else, put Helmbold's Buchu on the market for sale. And why! First, because, the law recognizes that it would be a fraud to use Helmbold's name. It would be a fraud upon the public, because its sale is effected from the fact that Helmbold is supposed to make it. Helmbold is held responsible by the people for his article. Helmbold's reputation is at stake, and Helmbold's name controls its sale. But it may be urged that my illustration is insufficient, in that it only applies to patent medicines; that the name in such instances becomes a trade mark, and is protected under trade-mark laws. But name and reputation control the sale of other remedies than patent medicines. It would not be a well-advised move for any other manufacturing pharmacists to put upon the market a preparation of ergot or ether, and call it Squibb's, though the formula for both Squibb's fld. ext. of ergot and for the manufacture of the ether are official in the Pharmacopœia. The great control, then, of the sale of all remedies is not in secret formulæ or in patents, but in the name. This is a recognized fact in all trade, be it patent medicines or legitimate pharmaceutical preparations. This is not to be decried, but on the contrary, encouraged, provided, however, it be a control which is gained entirely on merit. Furthermore, so true is the principle here asserted, that the same article,

only under a different name, could never be regarded by the consumer as in every respect similar. To use an illustration: Ayer's pills under any other name, though guaranteed to be the same by Ayer himself, would never have the sale belonging to the old preparation. A certain gentleman doing a large business in a tooth tablet of his invention once changed his paper box for a tin one, to preserve the contents on ocean voyages, and had a large part of the stock returned upon him as unsaleable, in consequence of the suspicion excited among the public. A rose, then, by any other name, will not smell as sweet. It has been asked, what's in a name? I answer, there is a good deal more in a name than the profession ever dreamed of. Take the two names, lactopeptine and peptoine pills, for example, or any other name coined to represent an article, as cincho-quinine, dextro-quinine, etc., if you please. The formulæ of preparations of this class purport to be published on the labels. Be that the working formula or no, the sale of the article is controlled by the name. Some of the names for articles of this description are patented at Washington. And it is rare, in any case, for any one to be so presumptious as to put out a preparation, though manufactured by the same formula, for competition. A great deal of money is spent in advertising those names, and trade-mark names become very valuable assets.

Now, in this matter of trade-mark names, it seems to me that the trade have got a little ahead of the medical profession in sharpness. I am not arguing here the legitimacy of prescribing them or of prescribing patent medicines. If a standard quality is maintained in the preparation, under the trade mark, it may be a protection to the prescriber. But it does occur to me that there is an absurdity somewhere. If Helmbold's Buchu, Ayer's Pills and Jayne's Vermifuge, are patent medicines, because their sale is controlled by a trade mark, is not every other remedy controlled by a trade mark a patent medicine? And if the profession prescribe remedies whose sale is controlled by a trade-mark name or label, are they not prescribing patent medicines? It is useless to argue about one being a secret and the other a published formula. The formulæ are not patented; it is the name which is patented. It makes no difference whether the formulæ are published or not, the patent, in either case, controls their sale and prevents competition, any representation that it is the name and reputation of the house, and not the name of the article, to the contrary, notwithstanding.

If all remedies whose sale is controlled by a trade mark be patent medicines, then are a great many drug concerns in the patent medicine business. The only difference between one class of patent medicines and the other is in the fact that the former are advertised to the people and the formulæ are not put on the labels, the latter are advertised to the medical profession, and the formulæ appear on the labels; but in either case their sale is controlled by a trade mark.

Now to my point. It is in answer to the question, what will become of the capital and ability invested in pushing remedies now advertised to the medical profession in the journals, if that advertising be stopped, or the use of those remedies discouraged? Don't you see the door wide open in the easy convertibility of one form of the same energy into the other? How easy to transfer the advertising from the medical journals to the secular press, the demand among the doctors to a demand among the people. And is not this transition already going on? Look in the daily papers and see. Behold, also, that the demand is made by the argument that the use of these remedies is sanctioned by the medical profession. You have heard of the boomerang—their use is sanctioned by the profession, and it has come back on them.

It is not the "therapeutic boom" that is derogatory to true progress in scientific medicine, though steady work is to be preferred to "booming," but it is unscientific, misleading advertising. Drug houses present remedies to the medical profession unsupported by sufficient scientific information. They control their sale by trade marks, and have everything their own way, in consequence. About the only scientific information ever presented is the insufficient statements of chemists. Because a compound has a certain chemical constitution, and therefore, theoretically, ought to produce certain effects, is no proof that it will produce such effects, when given in disease. Theory is of very little consequence except to account for positive facts. Facts are what we want in treating the sick; and the reason why a drug will produce certain effects will do to talk about after it has been proved to be able to produce those effects. Then, again, every means is taken to prevent competition by rival houses, and the profession will not report failures, lest they injure their practice thereby; so the truth is never known. There is no objection to a manufacturer saying to the profession that his goods are better than any other man's make, by proving it. Competition in quality is honorable. Competition in enterprise in securing new drugs, preparation, or

methods of manufacture, is to be commended. When the happy day dawns, of legitimate competition, then there will be no more mourning over poor drugs and the abuse of pharmacy.

And now, how do I propose to correct these abuses? By setting a good example myself, and urging others to follow it. This I have endeavored to do in the matter of desiccated blood, and by the help of the profession I hope it will be corrective in its tendency.

In the first place, then, desiccated blood is not controlled, either in manufacture or sale, by trade mark, trade-mark name, or patent, but appears simply under its scientific Latin name, "Sanguis Bovinus Exsiccatus." In the second place, there is no secret whatever in its manufacture; anybody, by selecting a first-class steer and sticking him over the heart, so that he may bleed to death, and not die of apnœa, can obtain the same blood used by Dr. Craven, at the Jersey City Stock Yards, taken from the choice picked steers for European exportation. By stirring this blood with sticks, and removing the small amount of adhering fibrin, it can be preventing from clotting. If, now, it be dried at a temperature of 110° F. and quick enough to prevent decomposition, a product equal in every respect to that made for me at the Central Stock Yards and Transit Company, of Jersey City, can be secured. In the third place, I have never allowed an advertisement to appear on the subject of Sanguis Bovinus Exsiccatus which did not contain the truth, the whole truth, and nothing but the truth, as far as it was possible at the time to obtain it. In the fourth place, knowing that the publication of only one side of the question, must, of necessity, be misleading, I devised a plan of presenting it to the hospitals all over the United States, to be followed by their official reports, founded on thorough scientific tests. In the fifth place, defibrinated blood had been used in more than 100 cases, and good results obtained, before a single advertisement appeared, or I felt justified in presenting it publicly to the profession. In the sixth place, I placed the sale of this article, as prepared by Dr. Craven, in the hands of a house who have backed me in my position in every particular. And furthermore, if Dr. Craven has contracted to furnish blood prepared by him to no other house, it is but to protect his own reputation and the quality of the article; he cannot control the sale, except on quality; all of which is perfectly legitimate. And in the seventh place, as quality can only be obtained by care and skill, when any other house can present to the profession Sanguis Bovinus Exsiccatus prepared with as much care and skill as exercised by Dr. Craven, and handle it with as much enterprise and ability as Messrs. Parke, Davis & Co., of Detroit, I will with pleasure commend their enterprise.

Finally, then, I respectfully request the profession not to wait until a new remedy becomes official in the U. S. P. before using it, but to thoroughly test all such remedies carefully, in numerous cases, in the hospitals and dispensaries, so that when they are presented for acceptance to the Pharmacopœia committee, at the next revision, there may be furnished concurrently, with every new drug, reliable information concerning it.

Hospital Reports.

ST. MARY'S HOSPITAL—EYE DEPARTMENT.

CLINIC OF H. AUGUSTUS WILSON, M. D.

Reported for the Medical and Surgical Reporter.

Catarrhal Conjunctivitis.

The first case for our consideration is that of Ellen K., aged 22, who comes here complaining of smarting and itching of the eyes, with lachrymation and photophobia, attributing her trouble to a cold. This is the usual history of such cases, for it seems to be instinctive to associate cause and effect; having an effect, patients try to find the cause, and "caught cold" will usually be found sufficient to satisfy most people, no matter what the disease.

In mild cases there is simple hyperæmia, the vessels being only slightly increased in size, and comparatively few in number, but tortuous and arborescent. There is generally a moderate amount of pain, together with lachrymation and intolerance of light, with a slight discharge of mucus. It is, however, only in the more severe cases that any room for difficulty in diagnosis occurs. The case before us has progressed rather further than this, but is still not one of what is known as trachoma, or chronic granular ophthalmia.

Before everting the lids I will call your attention to the increased number and tortuous condition of the blood-vessels of the skin of the upper lid; this indicates an inflammatory condition of the palpebral mucous membrane, and that that condition does exist I will now show you by everting the upper lid, and we see, in addition to the intensely injected condition of the whole conjunctiva, palpebral and ocular, a velvety appearance, particularly marked in the upper lid, which is due to the enlargement of the closely set mucous papillæ of the conjunctiva. These are what have been termed catarrhal granulations, and the case furnishes a beautiful type of this form of disease. These granulations assume varying degrees of hardness, depending upon the amount and character of

the inflammation. In the case before us they have assumed a sufficient degree of hardness to act as a constant irritant to the surface of the cornea, with which they come in contact, and as a result it presents the condition known as leucoma. That the haziness and opacity seen in the cornea are due to this cause is shown by its limitation to the upper segment of the cornea, the only part with which the granulations come in contact.

The first indication for treatment in this case is to subdue the general inflammatory condition to such a degree as to allow of the use of means directed to the removal of the granulations themselves. To this end we shall order her to bathe her eyes frequently in *hot* water, after which she is to apply an ointment composed of two grains of the yellow oxide of mercury to one drachm of vaseline. At our next clinic we shall expect to find this inflammation so far under control as to admit of the application of a mild astringent, such as ten grains of tannin to one ounce of glycerine, and in the course of a few weeks of this treatment, faithfully followed up, we shall hope to present her before you with a clean conjunctiva and transparent cornea.

Keep in mind, however, that any slight indiscretion on the part of the patient, such as exposure to cold, etc., may result in a backset which will prolong the case for months. Of course, we must direct that the best hygienic conditions possible to one in her walk of life be observed, as lack of proper care in this respect is a very fruitful cause of the disease.

Chronic Granulations from the Virus of Purulent Ophthalmia.

Mrs. A. C. complains of pain in the eyes, which she states has existed for two weeks, of increased lachrymation, and a somewhat purulent discharge.

Having now received her own account, we will proceed to examine the case for ourselves. In making an examination, it is an excellent plan to pursue much the same method for the eye as we would employ for other parts of the body.

The outer surface of the lids should first engage our attention; their edges, as to position, cleanliness, the state of the follicles and curvature of the lashes should all be carefully noted; also the position of the puncta with reference to the surface of the ball, and whether pressure will cause an oozing out of a secretion from them.

The lower lid may be everted by pressing the integument downward on the cheek, and at the same time directing the patient to roll the eye up. This brings the conjunctiva clearly into view.

The eversion of the upper lid is accomplished by directing the patient to look downward, pressing the integument of the lid well against the orbital bone with the right fore-finger, to cause the lashes to turn well out, then grasping its central lashes lightly between the thumb and fore-finger of the left hand, I fold the tarsal cartilage upward over a probe or pencil held at its upper margin in my right; or you may use your thumb nail, as you see me do now. In this manner you should proceed, carefully examining every part as you come to it. But we have seen enough to occupy our attention for a time, and without going on to make a minute examination of the deeper structures, refraction, etc., we will discuss what we have seen.

On the outside we find nothing of note but this little tumor, which is situated beneath the skin a little to the nasal side of the centre of the right upper lid, and about three lines from its margin. It is as large as a medium-sized shot, and the integument moves freely over it.

On everting the lid it shows itself as a very slight prominence on the under surface, and, no doubt, it aggravates the already inflamed condition of the palpebral conjunctiva by its pressure.

This is what is known as a chalazion, and is developed from what in common parlance is called a stye; being a blocking up of one of the meibomian follicles. The secretion, not being able to escape, accumulates, and the condition before you is the result.

Its proper treatment would be to incise and turn out the contents irritating its interior, so as to cause absorption; taking care to make the incision in the direction of the folds and creases of the integument, and if possible, *in* one of the creases, so as to conceal the scar.

The incision is sometimes made on the under surface of the lid, and a scar on the integument is thus entirely avoided; but, when you consider that this is done at the risk of leaving a cicatrix which may erode and cause an opacity of the cornea, you will agree with me that the former plan is the more desirable.

But this chalazion is not the cause of complaint with our patient, and as she declines an operation at present we will confine ourselves to the true source of her trouble. This we find to be an inflammation caused by a virus, and which has developed the granular bodies to be observed on both the upper and lower palpebral conjunctivæ.

An inflammation similar at first to what you saw in the last case has gone on to the granular stage, and embedded among the red, swollen papillæ of the conjunctival membrane we find small white bodies, most abundant on the upper lid, which appear white and opalescent, and about the size of small pin-heads. These have been called the "sago" granulations, and constitute a disease which is much slower in yielding to treatment than the ordinary catarrhal form seen in the last patient.

The first patient before us could trace her trouble to nothing but a cold, while here we have a distinct history of its having been derived from a purulent ophthalmia in the patient's little boy. The case is quite chronic, and demands a different course of treatment than the former one. The object is not, as many seem to think, the removal of the granulations in mass; hence we do not use such applications as will act to destroy them, but such as will stimulate their absorption. After the use for a few days of an astringent lotion of alum, to diminish the blood supply of the part, we shall begin our active treatment by scarifying the lower lids and applying a solution of tannin, ten grains to the ounce of glycerine, to the upper lids. This treatment must be repeated on each visit, three times a week. In addition to this, we shall apply an ointment composed of

two grains of the yellow oxide of mercury to the ounce of vaseline, whenever the exudation is sufficient to cause the lids to adhere in the mornings.

The question may occur to some of you, why not scarify the upper as well as the lower lids? Many eye surgeons do so; and the immediate effect on the granulations is better than by simple astringent applications; but rough cicatrices are sometimes formed by the healing of the wounds thus made, which serve as constant irritants to the surface of the cornea; and rather than run this risk I consider it far preferable to use applications which, though somewhat slower in their operation, are so much more satisfactory in the end.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

CLINIC OF JOHN ASHHURST, Jr., M. D.

Professor of Clinical Surgery in the University of Pennsylvania.

Reported by Wm. H. Morrison, M. D.

Excision of the Knee Joint for Gelatinous Arthritis.

Gentlemen—The first case I shall show you to-day is one of disease of the knee joint, in a little girl six years old. She has been suffering from this affection for four years. I learn from one of our nurses, who formerly was a nurse in the Pennsylvania Hospital, that the child was in that institution at the age of two years, suffering from the same disease.

The condition that we have here is that which has been called scrofulous synovitis, gelatiniform synovitis, gelatiniform degeneration, and a variety of other names, but I think a name that describes the condition more accurately is that which I have proposed for it—gelatinous arthritis. It is not simply a synovitis, for all the tissues of the joint, even the cartilages, are involved. The term gelatinous describes the condition of the tissues, which, when exposed, seem to have been converted into a gelatiniform mass.

In the early stages of this disease, which is perhaps the most common form of arthritis affecting the knee joint, and which, in its advanced stages, constitutes the white swelling of the older writers—in the early stages, I say, something can undoubtedly be done by fixation of the joint, keeping the parts perfectly at rest, and by counter-irritation, with the tincture of iodine or blister, by extension, if there is much pain from the contact of articular surfaces, and by proper constitutional treatment.

In the advanced stages, when the disease has progressed as far as it has in this case, I do not think that any treatment short of the removal of the diseased part is sufficient.

The surgeon should, of course, take away no more of the limb than is necessary for the removal of the diseased part. Excision is usually sufficient, but in more advanced cases, when the general health begins to fail, amputation may be required, and it then becomes a truly conservative measure; but as I have said, in the large majority of cases the surgeon will do better, I think, by simply removing the joint.

The operation of excision of the knee joint for disease is usually a successful one, in well selected cases. It is not a successful one when performed in cases of recent accidents, or after gunshot injuries; but when employed for chronic disease of the joint, and when the after treatment is carefully attended to, it is usually successful. The after treatment is a very important element.

The joint can best be reached by a transverse incision below the patella. As the object of the operation is to destroy the function of the joint, it is better to remove this bone. The skin and fascia being dissected up, the joint is opened, and the extremities of the femur and tibia removed with the saw. The best saw for this purpose is that of Butcher, with which the bone can be divided from below upward. In using this saw there is one point frequently overlooked by surgeons. When sawing from above downward, in the ordinary way, the force is applied in pushing the saw and the teeth are directed forward; but when the surgeon reverses the proceeding and saws from below upward, then the force is applied in pulling the saw toward him, and the saw should be reversed so that the teeth are directed backward. The other instruments required in this operation, are a strong scalpel, a blunt-pointed knife, to divide the tissues in the neighborhood of the popliteal space, when we get near the great vessels, and a pair of Fergusson's "lion-jawed" forceps, with which an assistant can steady the bone while it is being sawn.

No very large blood vessels are divided in this operation. The popliteal artery can only be wounded by carelessness. The articular arteries are, of course, divided, and require ligation. Unless the hemorrhage is great, I usually postpone the ligation of the arteries until the bone sections are made. I do not use a tourniquet or Esmarch's tube. I have seen a case where Esmarch's tube was used during this operation followed by consecutive hemorrhage which proved fatal. You know that one result of the use of Esmarch's tube is paralysis of the vasomotor nerves, and thus the risk of consecutive hemorrhage is rendered greater, and as we cannot, as in operations for necrosis, stuff the wound and control the hemorrhage by pressure, I think it better to avoid that risk.

Here you see the characteristic appearance of the joints in gelatinous arthritis. Notice the great globular swelling. There is a good deal of heat about the joint, showing that the disease is still in active progress. There is no great loss of motion. This is a characteristic of gelatinous arthritis. You will also observe the deformity, the leg thrown backward, rotated outward and drawn upward.

I do not think that anything can be done here, by orthopædic measures. After the operation I shall place the limb in this splint, which is the best I know of for this purpose. It is made of wire, and secured to the thigh and to the leg, thus leaving the joint free, so that it may be examined and dressed without removing the splint. It also has a movable foot piece, to adapt it to limbs of different sizes.

I now make an incision across the front of the joint, and when the limb is straightened out the

tissues will form a flap. A precaution to be taken in making this incision is to get the ends far enough back to allow free drainage. I cut directly down and disarticulate the bones. You see how completely the joint is obliterated by this gelatinous matter. I now remove the articulating surface of the femur. As these bleeding vessels will have to be tied, sooner or later, I may as well tie them before I go on. Now, taking the blunt-pointed knife, I divide what is left of the crucial ligaments. I cut cautiously backward until I get behind the articulating surface of the tibia. I remove with the saw as thin a shaving as possible of the the tibia. I bring the leg down, and you see that it comes out pretty straight, but I think it better to remove a little more from the tibia. The leg can now be brought perfectly straight.

An important point to be borne in mind in performing this operation is not to interfere with the floor of the popliteal space, for if you cut the ligamentous tissues at the back of the joint, you not only endanger the blood vessels, but you open up a way for pus to escape into the tissues of the thigh and leg. One of the most troublesome sequelæ of excision of the knee-joint is burrowing of pus up and down the limb; but by keeping the floor of the popliteal space intact, this complication can usually be avoided.

Here you see this bursa extending up above the patella. This I shall have to remove, for if allowed to remain it will continue to suppurate indefinitely. In the adult this cannot always be done, for sometimes the bursa extends a considerable distance up the thigh. I have known it to extend four or five inches. Of course, under such circumstances, it becomes a serious matter to attempt its removal.

While the limb is being washed, we will take a look at the bone. Here you see this gelatinous mass, uniting all the parts together. The synovial membrane is entirely obliterated. This is all that is left of the semilunar cartilages. When I cut into this, we find the cartilages eroded—what used to be called ulceration of cartilage. Below this we find caries of the superficial layer of bone. This inflammation, and caries of the bone is the cause of the pain in this disease. It is probable that cartilage is not possessed of sensibility, and that the pain is due to the disease of the bone immediately underneath. We find the same condition of things in the slice removed from the tibia. This yellowish-looking material outside of the joint is not, as is sometimes supposed, the result of gelatiniform change, but is simply a fatty degeneration of the surrounding tissues. The gelatiniform change is, I think, confined to the synovial membrane and the cartilages. There is no specific difference between this form of arthritis and the ordinary form which often ends in anchylosis. The difference is, that in gelatinous arthritis the gelatinous material does not become perfectly organized and form adhesions, but simply remains in this soft condition.

Before applying the splint I shall introduce a few stitches and bring the edges of the wound together. This splint is made in three parts. I shall pad the parts to be applied to the thigh and leg, but I shall not pad the middle part until the splint is fixed. The splint is secured to the thigh and leg by broad pieces of adhesive plaster, and to the foot by the foot-piece. Over this I apply a roller bandage. The limb is now securely fixed, and the wound can be dressed every day through this opening. The dressing for the wound consists of a piece of oiled lint, over this oiled silk, and then the knee is surrounded on all sides by oakum, held in position by a roller bandage. The limb will be placed on a soft pillow, but in case the child is restless, it will be better to put it in a fracture box. In the subsequent dressings we shall use the Scultetus bandage, as it allows the wound to be dressed with a less amount of exposure than the ordinary bandage.

[The patient did well for two or three weeks; then the wound, which had united, reopened, and the femoral epiphysis came away as a sequestrum. An intercurrent pneumonia followed, and proved fatal on the twenty-ninth day.]

Sub-astragaloid Amputation of the Foot.

The next case is the one of which I spoke to you last week. A case of very bad acquired club foot, coming on in childhood. It is accompanied by so much disease of the bones that I have recommended amputation of the front part of the foot. The loss of bone, whether by caries or by interstitial absorption, is so great, and the deformity is so marked, that I do not think any benefit would be derived from orthopædic measures. At this point there is beginning ulceration, a perforating ulcer, as it is called, a peculiar form of ulcer, resulting sometimes from pressure, or exposure to cold, and sometimes from degenerative nerve changes.

You see how deformed the foot is. You see these sinuses, which I think lead to diseased bone. Passing the probe through one of them, I can feel carious bone.

The operation which I intend to perform is that of sub-astragaloid or Lignerolles' amputation, consisting of the removal of all of the foot except the astragalus. The incisions are made very much as for a Syme's operation, but the astragalus is left, the os calcis is dissected out, and the lower flap is then brought over the astragalus. It is something between a Syme and a Chopart. Lignerolles employed two lateral flaps, and Lisfranc took one flap from the dorsum of the foot. The dorsal flap is, of course, much less resistant than the heel flap. The best method is, I think, that recommended by the late Mr. Hancock, of Charing Cross Hospital, London, and the one which I have also pursued in my operations. It consists in making the heel flap as in Syme's amputation. The operation is more tedious. It takes a long while to dissect out the calcaneum; but I think the results are so favorable as to warrant the expenditure of time.

I first make a dorsal flap, as in Syme's operation. I cut off the anterior part of the foot, and then proceed more leisurely to remove the os calcis. I dissect it out, keeping as close as possible to the bone. Sometimes the projecting part of the astragalus may be removed, allowing only the portion between the malleoli to remain, and this is the plan which I shall adopt in the present instance.

The object of this operation is to preserve the

ankle joint, enabling the patient to walk with considerable elasticity of step. I think that it is better than Pirogoff's, which does not preserve the joint.

I have made a slight perforation in the heel. One of the directions given by Mr. Syme for the performance of his operation was, that the surgeon should make an opening through the heel, to allow the escape of any fluids that might collect. This is the operation I advise you to perform when you have to go higher than a Chopart and not as high as a Syme. It has the advantages that it preserves the ankle joint, and leaves a longer stump.

Having ligated the vessels, I bring the wound together by silver sutures, and give support by adhesive strips. This, having the natural heel tissues for its base, makes a good stump. I dress it, as I do all amputations, with pure laudanum. Over this I put oiled silk, then a mass of oakum, and complete the dressing with a roller bandage.

[The patient recovered without a bad symptom, and with an excellent stump, which readily bore her weight in walking.]

Editorial Department.

Periscope.

Medical Use of Burgundy Wines.

The *Lancet*, Oct. 23, says:—

The therapeutic value of red Burgundy wines is very marked, but the potency of their effects must make physicians somewhat cautious in recommending them, although in many types of disease no class of wine will produce so great benefit. They are well fitted for convalescents from fevers and other acute affections, and are superior to all other wines in cases of anæmia, general debility, feeble development, and cases of mal-nutrition not depending on gastric or intestinal irritation. Even if such be present, they may frequently be prescribed with benefit, although lighter, and especially sparkling, wines agree better if the irritability be a marked symptom. In most cases in which iron and cod-liver oil form the routine treatment, a wine-glass or two of good Burgundy with dinner is an excellent adjuvant. Primarily somewhat stimulating, these wines in their after-effects are markedly sedative, and hence many patients, weak in physical powers, but excitable and highly nervous in temperament, derive more good from them than from other classes of wines. In some cases this sedative influence may render unnecessary the ordinary soporifics, and chloral, opium, and bromides be now and again dispensed with. They do not aid the digestion as clarets often do, nor can they be taken as refrigerants; in fact, Burgundy is a very powerful wine, must be ordered with great care, and taken in small quantities only. It is said to favor the development of obesity, but we much doubt if this be a fact when the wine is taken in medicinal quantities. The excessive eating with which Burgundy drinking is so generally accompanied has, perhaps, as much to answer for in the production of this condition as the mere consumption of the wine. It is stated that in the Burgundy districts gout is not a prevalent disease, even among the growers and exporters of the best wines; but gouty patients can only take it sparingly, if indeed it be ever advisable. Bilious and plethoric people cannot take this class of wine with safety, and in many of these patients headache and a sense of fullness and discomfort are induced by even small quantities. The amount of sugar is so small that it may be safely ordered for diabetics, and the superiority of the best wines in this respect has already been referred to. The amount of fixed acid is much the same as in clarets; this, with the lower percentage of grape-sugar, make it even more valuable in many cases of rheumatism and neuralgia. It is important to remember that the best red Burgundies contain more alcohol than the corresponding clarets; and that in even the cheaper varieties, including Mâcon and Beaujolais, a similar difference exists. White Burgundies of the highest class, such as Montrachet, contain even more alcohol than Romanée or Chambertin, and as a large amount of unfermented grape-sugar is also usually present in such wines, they are indicated in different cases of disease, and cannot be safely substituted for one another.

A Case of Antiseptic Midwifery.

Mr. Walter Verdon, F.R.C.S., writes to the *Lancet*, September 25th:—

The following case is, I think, of interest, in showing the value of Mr. Lister's treatment applied to midwifery.

Lately I have used antiseptics in ordinary midwifery cases, and with marked benefit. The discharge ceases sooner, and does not become offensive. In some cases this disappears entirely during the first week. It is necessary, however, in order to obtain a good result, to guard against the admission of septic air both during and after confinement; to view the uterine and vaginal lesions in the same light you would the wound made in a subcutaneous operation, and as carefully protect them from septic influence.

Mrs. T., weak and anæmic, at full time, had suffered from frequent pains for two days. She had not sent for assistance, because she did not think the labor far enough advanced, but now felt so exhausted she wished for help. The os was now fully dilated, membranes ruptured, head above the brim, pelvis roomy, pains frequent and short; the head descended with and receded after each, making no progress; pulse 98, weak and compressible; the patient was much exhausted. I then determined to use the forceps, and also to take every antiseptic precaution.

I syringed out the vagina with warm carbolized water; also had a small basin of carbolized oil at hand for the instruments, hands, etc., and to anoint the labia and adjacent parts. All vaginal manipulation was performed beneath the spray, and with very little traction the child was born. The after-applications were diapers soaked in carbolized oil and carbolized tow, and an injection of carbolic lotion three times daily.

On the second day after confinement I found the nurse was suffering from an acute attack of erysipelas of the face; she told me she was feeling ill, and her head felt tender the day before the confinement. She had slept with the patient on the night of the labor and on the following night.

On the third day the patient complained of sore-throat. Pulse 120; temperature 102° F. Vaginal discharge free from putrefactive smell; urine clear and copious.

On the fourth and fifth days the patient felt very ill, and complained of pain in the right leg. Her tongue was coated; pulse 120. Still the vaginal discharge was going on satisfactorily, but there was a patch of cutaneous inflammation on the right thigh, from the buttock extending almost to the knee.

On the sixth day the discharge ceased and did not return. The pulse remained above 100 until the eleventh day; the redness disappeared on the eighth day.

The child also was the subject of an unhealthy ulceration round the umbilicus, preceded by a superficial inflammation extending to the groin.

Both the child and mother made a good recovery.

Cold Baths in Cerebral Rheumatism.

Dr. Woillez has read an able paper upon this subject at the Academy of Medicine (*Union Méd.*, October 14). After adverting to the former fatality of the disease, he states that since 1870 it has become more and more evident that it may almost always be successfully treated by the application of cold, the cold bath at 20° C. (68° F.) being the form of using it which he prefers, repeating it every three hours, until the cessation of the delirium and the reappearance of the swelling of the joints. Generally the cessation of the cerebral accidents only lasts for a short time after the first immersion, but gradually increases in duration after the subsequent ones, a refreshing sleep succeeding the period of agitation. When the baths cause shivering they should be discontinued. In no instance in which they have been employed have they given rise to mischievous effects; and even when, owing to their defective application, they have not prevented death, they have prolonged life. They may be prescribed under the following conditions:—1. When to the delirium there are added diminution or disappearance of the swelling of the joints and a temperature of 40° C. (104° F.) and above. Under this combination the baths may be said always to succeed in procuring recovery at all periods of the disease, whether there be only delirium, coma, or imminence of death. 2. We should have recourse to them if with the delirium there is no diminution in the articular symptoms, but the hyperthermia exists. 3. The bath should be replaced by revulsives when merely delirium prevails, the articular disease pursuing its course, and no hyperthermia being present. Dr. Woillez observes that it is an error to regard the hyperthermia as the sole indication for the employment of the cold bath, the articular fluxion requiring also to be taken into consideration, since, in a certain number of cases, revulsive treatment having caused this fluxion to reappear, a cure has resulted. Although so strong an advocate for the cold bath in cerebral rheumatism, he does not regard it as opportune in all general diseases with high temperature, and especially in typhoid fever, in which he considers it as ineffectual and injurious.

Some of the Therapeutic Uses of Iodoform.

According to the *British Medical Journal*, October 2d, 1880, Dr. Henry M. O'Hara read a paper on this subject, before the Victorian branch of the Society, April 16th, 1880.

He said that during his voyage from London to Melbourne he treated six cases of soft chancre in sailors, by dusting the sores, night and morning, with powdered iodoform. Five of the six healed rapidly and no ill effects followed; but the sixth case, a strumous-looking man of twenty-six, showed symptoms of bubo. Dr. O'Hara therefore stopped the treatment, and put him on black wash and iodide of potassium. This treatment failing, he again ordered the local application of iodoform, and in eight days the sores took on a healthy action and began to heal. On undertaking the duties of out-door surgeon to the Alfred Hospital, he introduced iodoform, and kept a record of the cases treated with it during twelve months. During that period he prescribed it in 40 cases of chancre, in 32 of chronic indolent ulcer (principally the so-called varicose ulcer), in 3 cases of ozæna, and in several cases of ringworm. Of the 40 cases of chancre, 31 reported themselves cured. The average duration was eighteen days. Two patients returned with sore throat and secondary symptoms, and the remaining seven were lost sight of. This gives an average of 77 per cent. absolutely cured. Of these 31, 21 were simply treated by the topical application of the drug in an ethereal solution; the other 10, not healing so rapidly, took one grain in pills, three times a day, of iodoform. Of the 32 chronic cases, 23 were in women and 9 in men. In every case there was a varicose condition of the veins of the leg, and Dr. O'Hara prescribed iodoform ointment (twenty grains to the ounce) and a bandage. Of these 32, 26 healed rapidly (some were of very old standing), but 6 defied the iodoform at first; and, having strapped them for a short time, he again tried iodoform, when four of them healed; the other two he lost sight of. It was only in the chronic indolent ulcer that iodoform acted so beneficially. On inflamed surfaces it increased the inflammation and acted as a violent irritant. The same result was found in the case of chancres. In ringworm Dr. O'Hara was very much disappointed with the results of his experiment; and, of 12 cases, he

had in all to fall back upon chrysophanic acid. In conclusion, Dr. O'Hara pointed out that iodoform was quick in its action and gave no pain; in the majority of cases he found its local application sufficient; and that it was very portable, being prescribed in pills which could be carried about by the patient.

Treatment of Diffuse Phlegmon.

Prof. Peter, in one of his clinical lectures published in *le Presse Méd. Belge*, Sept. 5, 1880, states that formerly he agreed with others in the great utility of multiple and prolonged incisions in diffuse phlegmon, so that in one case he practiced no less than seventeen incisions, of from twelve to fourteen centimetres in length. Since that period he has reflected that such incisions may prove mischievous in alcoholic and diabetic patients and others who can ill bear the consequent loss of blood. Fortunately he has found that the phlegmon may be effectually treated by a much milder procedure. In all patients who exhibit a diathesic condition from heart affection, albuminuria, diabetes, alcoholism, etc., he is very chary in making incisions; and if they must be resorted to he employs the actual cautery, while the thermo-cautery is the best means for treating anthrax. Even when no diathesis forbids them, he now abstains from multiple and large incisions, and seeks for the nearest serous bursa, as almost all diffuse phlegmons originate in a natural or artificial bursa. He makes one, or at most two, cuts with the bistoury opposite this bursa. For phlegmon of the thigh this is done at the bursa of the patella; for that of the foot the incision must be made at the two malleoli, and for that of the forearm the bursa of the olecranon must be opened. Almost always one such incision suffices, but if the phlegmon persists the incision must be repeated next day.

The Therapeutic Use of Pilocarpine in Skin Diseases.

In the St. Petersburg *Med. Wochenschrift* of 19th July, quoted in London *Med. Rec.*, appears a notice of the results obtained by Professor Pick from the use, over a space of two-and-a half years, of pilocarpine and its preparations in prurigo, psoriasis, eczema, pruritus, urticaria chronica, alopecia areata, trichoptilosis, alopecia pityrodes, acne, hyperidrosis, pemphigus chronicus, and lichen exsudativus, *i.e.*, in all skin-affections where the secretion of sweat is more or less altered. Small doses of one-sixth of a grain, in solution, were ordered twice a day, one to two hours after food. Perspiration followed generally four or five minutes afterwards. After several weeks' use, unless intermitted, the dose had to be increased. The skin became softer and more pliable, scaliness diminished, and the hair was less brittle. The use of the remedy even for months in no way disturbed the general health. In 32 cases of prurigo the tormenting itchiness disappeared, and the relapses were somewhat delayed; while, again, in 25 cases of psoriasis no effect was seen. In two cases of pruritus senilis, and one of urticaria, a cure was accomplished. In eczema, the result was not decided. In ten cases of alopecia pityrodes, good results followed; while in four cases of alopecia areata, no decisive result was obtained.

Credé on Nerve Stretching.

At the last meeting of the Society of German Surgeons, in Berlin (*Med.-Chir. Centralblatt*, No. 31), Dr. Credé, of Dresden, showed a patient on whom he had performed stretching and division of the third branch of the trigeminal nerve by a modification of Lücke's method. He made an incision down to the posterior surface of the upper jaw. The lower jaw had to be dislocated; he then penetrated beneath the periosteum as far as the foramen ovale, seized the nerve with a blunt hook, and isolated the middle meningeal artery. He then stretched the nerve, and cut it through at the base of the skull. There was no febrile reaction; and the neuralgia was removed.

A long discussion followed on the usefulness of nerve-stretching. Opinions were divided. Esmarch had carried out nerve-stretching seven times with good results; once he had stretched the brachial plexus, in tabes, with success. Trendelenburg was not so fortunate; he had employed nerve-stretching in six cases, with only one example of success. He was undecided whether nerve-stretching was indicated in tetanus or in tabes. Sonnenburg did not observe any success in tetanus. Vogt laid emphasis on the point that the nerves must be very strongly stretched, and that only the large nerves could be treated. Langenbeck reported that in the cases which he had published of nerve-stretching in tabes, relapse had occurred; and so also in the case of intercostal neuralgia which Nussbaum, on his part, had reported.

Scirrhus of the Female Breast.

At the meeting of the Glasgow Pathological and Clinical Society, held May 10th, 1880, the Glasgow *Medical Journal* says:—

Dr. Foulis showed a series of seven specimens of scirrhus of the female breast, specially prepared to show the relation of the cancer mass to the nipple. In some of these the nipple was involved, but in such a manner that there was a line of demarcation by fatty subcutaneous tissue between the cancer of the nipple and the main mass of the cancer, the communication being along the ducts. In others of the cases the cancer seemed to drag in the nipple merely by dragging mechanically upon the ducts, and the cancer mass seemed to be quite apart from the nipple. In a third variety the cancer had infiltrated the nipple ducts and the septa of the gland far and wide, and in this variety there were several masses of cancer here and there in the breast, only united by the infiltrated septa. He placed the specimens on the table to compare with Dr. Forrest's case, in which, although the nipple was the seat of a precursory eczema, yet the main nodule of the cancer was far away from it in the axilla.

Effects of an Exclusive Meat Diet.

Mr. C. F. Masterman writes as follows to the *Lancet*, Oct. 2, 1880:—

In answer to the query of "Dietetic," I may point out the fact that the diet of the gauchos of South America consists almost exclusively of meat, and of a kind not containing much fat; they eat occasionally a little maize or roasted mandioc (Cassava manihot); but for weeks together they live entirely upon meat, and certainly enjoy excellent health. I do not remember having seen any trace of scurvy among them. But I can give a case more to the point in my personal experience. While I was a prisoner in Paraguay, during the Brazilio-Paraguayan war, my captors gave me literally no other food during two months than meat (about half a pound to a pound per diem) and water, and for the next month a similar diet, but with less meat, and about thrice a week a very thin cake, certainly not weighing more than an ounce, of cassava meal. I suffered much from thirst, for very little water was given to the prisoners, but still more from a craving for vegetable food. Nevertheless, my health was excellent the whole of the time. I became, of course, as lean as a starved greyhound; but when I was rescued by the expedition sent by the Government of the United States for that purpose—under the fortunate mistake that I was a subject of the Republic—I was really as well as I had ever been during a singularly healthy life.

Abnormalities of the Colon and Omentum as Causes of Reflex Psychoses.

In this paper, which was read before the Berliner Psychiatrischer Verein (*Allg. Zeitschr. für Psych.*, Band xxxvii, Heft 2), Dr. Fraenkel revivifies, as it were, some of the old views as to the special relations of diseases of the alimentary tract to melancholia and other mental disorders. Esquirol and Schroeder van der Kolk fully recognized this relationship; but since the days of Griesinger it has been ignored. Besides the previously described lengthening, displacement, etc., of the colon, the author has frequently noted in his cases irregularities in the position, etc., of the great omentum; these had apparently never been described by Schroeder or other writers. Dr. Fraenkel considers them to be of greater significance than the affections of the gut itself, inasmuch as adhesions and folding of the omentum must give rise to tension and pressure of the nerves contained in it. The peripheral irritation thus caused is perceived by the ganglion cells of the brain cortex, any part of which may, in the author's view, be affected, thus causing psychoses of all kinds. Twenty-five cases are tabulated in this paper; in six the omentum was rolled up and hidden behind the stomach and descending colon, the transverse colon was at the same time arched downward; in four the omentum was affected as above, but the length and position of the colon was normal; in seven the omentum was shortened; in two it was adherent to the parietal peritoneum; in two it was adherent to the pubic bone; in one both colon and omentum were displaced upward and to the left; in two the transverse colon was arched downward, but the omentum only slightly displaced; in one the transverse colon was S-shaped, and displaced upward and to the left, but the omentum covered the whole of the front of the abdomen. Among the above were nine cases of general paralysis, all of which exhibited during life either decided mental depression, or only very slightly developed large delusions. The cases given extended over about four years, and occurred among fifty necropsies made during that period, about half of which were cases of general paralysis. The author's conclusions are these: 1. Abnormal positions of the colon and great omentum may cause a psychosis, or unfavorably influence one which already exists. 2. Percussion of the abdomen is recommended for the diagnosis of this condition. 3. Cold, wet compresses to the abdomen are frequently of use in the treatment.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——A reprint from the Report of the Michigan State Board of Health contains a valuable paper on "Light in the Public Schools and School Life in Relation to Vision," by Prof. C. J. Lundy, M.D.

——"Medical Hints on the Production and Management of the Singing Voice" is the subject of a monograph by Lennox Browne, F.R.C.S., published by M. L. Holbrook & Co., New York. Those interested in the cultivation of the voice will receive many useful hints from this little book.

——We have received the *National Temperance Almanac and Teetotalers' Year Book*, for 1881, published by the National Temperance Society, New York. It contains, in addition to the calendar and astronomical calculations, the latest and most reliable statistics of intemperance, official tables of internal revenue receipts, beer and the brewers, results of prohibition, full tables of leading officers of National and State Good Templars, Sons of Temperance, Templars of Honor and Temperance, Women's Unions, State Temperance Societies, etc.; a list of all temperance newspapers, New York City temperance organizations, eighteen choice engravings, with stories, illustrations, puzzles, etc. It also contains two shadow-pictures by Edward Carswell, entitled "How to Fight the Giant," and "Chain the Beasts." Price, ten cents, single copies, $1 per dozen, $7 per hundred. Send for it. Address J. N. Stearns, Publishing Agent, 58 Reade Street, New York City.

BOOK NOTICES.

The Art of Prolonging Life. By Christopher William Hufeland. Edited by Erasmus Wilson, M.D., Author of "A System of Human Anatomy," etc., etc. From the last London Edition. Philadelphia, Lindsay & Blakiston, 1880. Cloth. Small 8vo, pp. 298. Price $1.00.

There are few works the perusal of which has given us so much real pleasure, combined with useful information, as the one before us, and Dr. Wilson is certainly entitled to the gratitude of the English-reading public for having reproduced, in elegant form, one of the finest literary productions of the last century. Although the general diffusion of sanitary knowledge has increased wonderfully during the past hundred years, we must confess, with the editor, that we were surprised to find the little real progress which has been made in the science of living during the same period. The book is divided in three parts. Part I treats of the art of prolonging life in general, beginning with a review of the state of this science among the ancient Egyptians and Greeks, and in the middle ages. This is followed by an inquiry into the nature of the vital power and the duration of life in general, discussing separately the duration of life of plants, the duration of life in the animal world, and the duration of the life of man. Here the author shows that the age of the world has no influence on the duration of human life, explaining the apparently incredible age of the patriarchs as depending on the difference in the chronology of the early ages. He goes further into the examination of the influence of climate, occupations, temperature, etc., on the duration of life, and the various methods devised for its prolongation.

In part II the means which shorten life are laid before us. Among these are delicate nursing in infancy, physical excess in youth, overstrained exertion of the mental faculties, diseases and their injudicious treatment, suicide, impure air, intemperance in eating and drinking, with refined cookery and the use of spirituous liquors. Passions and certain dispositions of the mind, such as melancholy, care, dejection, fear, (especially fear of death), anxiety, faint heartedness, and, in particular, avarice and hatred, he regards as inimical to long life, as well as idleness, inactivity and languor. Also overstrained power of the imagination, imaginary diseases, sensibility, poisons, physical as well as infectious, and old age prematurely ingrafted on youth.

In part III he takes up for discussion the means which prolong life. These are good physical descent, prudent physical education, active and laborious youth, abstinence from physical love in youth, and a too early assumption of the married state, happy married state, sleep, bodily exercise, the enjoyment of free air, moderate temperature and warmth, rural and country life, traveling, cleanliness and proper care of the skin, proper food, moderation in eating and drinking, preservation of the teeth, mental tranquillity and contentment, keeping our passions subdued, and considering life, not as an object, but as the means of attaining higher perfection, employing every day as if it were our last, and having trust and confidence in mankind. Hope, joy and laughter are among the means which prolong life, and so is reality of character, while living under disguise or restraint, and assuming a false character is extremely prejudical to life. Agreeable stimulants of the senses, such as music, painting, poetry, he considers of the highest value.

The prevention of diseases and their judicious treatment, together with the proper use of medicine and physicians, form the subject of an interesting chapter, in which the author warns the public against using medicine without sufficient cause, saying that it is much better to prevent diseases than to cure them. His advice is to consult a physician, not so much respecting prescriptions, as the state of one's body. In choosing a physician we should avoid those who prepare and employ secret medicines, or who are too talkative or inquisitive, or who value themselves above others, or whose principal object in practice is avarice or ambition, and select one of good moral character, and if possible, a friend. Having made our choice, we should trust ourselves to him with confidence, and never follow the example of those who believe that the more physicians they collect around them the more certain they must be of relief, but always remember that one physician is better than two, two than three, and so on in proportion; in other words, that in the same ratio as the number of physicians are increased will the probability of cure decrease. We might go on speaking of his excellent precepts for the proper treatment of old age and his advocacy of the cultivation of the mental and bodily powers, etc., but space forbids. The book deserves to be carefully read by all intelligent and thoughtful men and women.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA

IS MEDICINE A SCIENCE OR AN ART?

The above question may seem one that has been answered. Few young men in the profession but fondly believe that it is a science, or if it is not one just yet, it is in a rapid gait and on the high road to become one.

Certain it is that it is becoming rapidly surrounded with all the paraphernalia of a science. We have a medical chemistry, medical physics, medical mechanics, medical mathematics; the student must devote years to questions of optics, analysis, acoustics; he must provide himself with thermometers, reagents, and 'scopes and 'meters without number; he is diligently taught that "instruments of precision" are his indispensable aids; and if he is bright and ambitious, he studies diseases profoundly—in the pathological room—and remedies thoroughly—in the physiological laboratory.

Yet in spite of this brilliant array of resources there are here and there some voices—rather timid and feeble ones, perhaps, but audible—which are raised against this tremendous cram. These mediæval-minded doctors do not seem to think that the chief end of medicine is diagnosis; they apparently pretend that we can learn more by watching the effects of medicine when administered to sick men than to healthy dogs; and they talk as if a student could spend his time better by the bedside of a patient than with his microscope over prepared slides.

Of course, the enlightened editor can have no sympathy with these obscurantists, who would sink the noble science of medicine down to the level of a healing art, but he still recognizes it as his duty to chronicle their existence; and lest his mere statements should be doubted he will feel it incumbent to "name names."

One of these doubting Thomases is Dr MATTHEW CHARTERIS, Professor of Materia Medica at the Glasgow University. He deflects so far from the recognized standard of science as to say, in a recent address—

"Clinical experience shows how few symptoms or signs are in reality significant of any one particular disease, and how slowly but surely the art of healing will be consolidated, *not by physiological experiment or laboratory dreams*, but by carefully recorded facts and well authenticated recoveries, when the proper remedies have been judiciously chosen."

This is full of heresy. What! If the symptoms and signs are not significant, where's the diagnosis to come from? To be sure, Prof. CHARTERIS replies, from personal bedside observation. But then the reagents, the 'scopes and the 'meters, they seem to be put secondary and in the shade, by this way of reasoning. Then that hit at "laboratory dreams" is really cruel to "scientific workers," who just now have so many "provings" to report in the journals.

The painful confession must further be made, that Prof. CHARTERIS does not stand alone as a skeptic of the modern methods. Last year a professor of the ancient school of Montpellier, Dr. J. QUISSAC, published in Paris a treatise, entitled *Thérapeutique Médicale*, a respectably big book. He is an out-and-out doubter. He talks thus in the preface:—

"Medicine is being removed further and further from the bases on which it should rest, and apart from which it cannot exist.

"Many a time a single symptom furnished by physical or chemical exploration is taken as a sufficient indication for remedies.

"What wonder, therefore, that the therapeutics of the day is little more than a field for experiment, and that a remedy good to-day will be worth nothing to-morrow. * * *

"It is not in the laboratories, no matter how well furnished, that we shall find the elements necessary to determine morbid conditions.

"As for the physical and chemical means, the microscope, the thermometer, the hematimeter, the sphygmograph, reagents, etc., etc., which fill so important a place in modern medicine, although we recognize their high value as scientific instruments, we consider them very feeble auxiliaries—indeed, often deceptive and dangerous—when we enter the domain of practical medicine."

Thus the professor of Montpellier; and in this spirit he teaches at the ancient University.

There seems, in truth, a growing disappointment at the practical benefits derived from the enormous multiplication of "instruments of precision" during the last thirty years. Nowhere have they been more sedulously cultivated than in Germany; but one has only to examine the records of German hospitals, or to glance at the confused and conflicting therapeutical paragraphs in *Ziemssen's Cyclopœdia,* to satisfy himself that clinical medicine has positively retrograded there since the days of Niemeyer—the last and greatest of Germany's real physicians.

Again, the feverish impatience with which every new remedy is run after by the profession, only to be tried, written about for a few months, and then thrown aside as a child does its toy, indicates surely that the old and standard remedies are too little known from their clinical side, and that, as Quissac says, the custom of seeking drugs to meet single indications, administering them on principles derived from physiologic[illegible] tests, is an utterly mistaken one.

MALIGNANT CHARBON.

The Academy of Medicine of Paris is at the present time, as we learn from an interesting article in *Le Concours Médical,* engaged in the discussion of 'le Charbon,' that infectious disease, oftenest seen in sheep, and which has attracted so much interest of late years through the experiments and researches of Pasteur, Colin, Bouley and other French savants.

This malady attracts great attention in France, for it destroys great numbers of sheep in certain parts of that country, particularly in 'La Beauce,' and there is one farm in particular, located near Senlis, on which every animal introduced, even if kept entirely apart from the others, will be attacked with the disease; the temperature rises to 41°–42°, the glands become inflamed and suppurate, death generally ensues, and at the autopsy the blood is found filled with bacteria.

How infection occurred in such a case has long been a disputed question, which has lately received a very probable solution, through the researches of that great savant in such matters, M. Pasteur; he asserts that the germs or bacteria of this disease are transported from the depths at which diseased animals are buried, by the earth worm which feeds on their carcasses, and he has demonstrated the presence of such bacteria in the excrements of the worms found on the surface, where the sheep in feeding would readily absorb them.

Some very interesting experiments have been lately reported to the Academy by M. Toussaint; he inoculated sheep with the serum of the blood of diseased animals, deprived, as he thought, of bacteria; he announced that after an attack milder than the usual disease this vaccination gave immunity against further attacks.

M. Bouley has repeated the experiments at Alfort, on twenty sheep; four died, and numberless bacteria were found in their blood; the others were gravely attacked, but recovered. In order to test M. Toussaint's assertion that such inoculation gave immunity against the disease, these sheep were inoculated from the blood of a rabbit dead after inoculation with virus of le charbon; the only result observed was a slight rise in the temperature, with some general malaise, showing that the virus had still some slight effect; this same effect somewhat more marked, for the glands were swollen, was remarked by M. Chauveau after inoculation of some Algerian sheep, who do not generally suffer from the disease when exposed to it; he

remarked also that repeated inoculation gave almost entire immunity from evil effects.

Have these facts any bearing on vaccination in the human subject? They would seem to show, as M. Bouley observes, that repeated vaccinations at short intervals, and with a greater number of points of inoculation might prove successful when one vaccination did not.

But M. Toussaint's process really resembles the direct inoculation of the virus of the smallpox, as has been practiced by the Chinese for the last thousand years in the human subject.

In the second half of the last century, when this direct inoculation was common in the north and centre of Europe, Gatti-Pisa, one of the great upholders of this practice, noticed that in 95 out of 100 cases direct inoculation could be made a second time with effect, showing that just as M. Toussaint has found to be the case in animals, for the charbon, so in man, inoculation, even with smallpox virus, would have to be repeated to confer perfect immunity against the disease.

"MAISONS de SANTÉ" IN CITIES.

We have at various times spoken of the advantages that accrue to the public from institutions in large cities to which a physician can send cases, treat them himself, and feel assured that they can have comfortable surroundings and careful nursing.

The need of such an establishment is often felt in large cities, both by the profession and by the public. To the physician it furnishes a place for those cases which daily present themselves, that cannot be attended with the best advantages at home, either through the absence around them of persons taking enough interest in their welfare, or want of means to employ competent persons to give the care necessary for a favorable issue. To the surgeon, it is of great value, success being enhanced by the certainty of proper after treatment, close observance of directions, and by the continuous presence of a medical man in case of secondary hemorrhage or other emergencies. In other words, it presents all the advantages of a hospital, while its privacy makes it acceptable to persons who would not enter one. The fact of being open to the general profession does away with the necessity of transferring the case to a hospital staff, which is the rule in these institutions, a fact evidently unpleasant for the doctor, and often disagreeable to the patient. To members of these staffs it is a convenient place for cases requiring systematic treatment, but who refuse to enter a public institution. To the physician practicing in the country or other cities, who desires to send cases to specialists, such an establishment presents many advantages. The physician in charge of the "Maison de Santé" being advised in advance, the patient is sent for at the station and the treating physician selected notified at once of the arrival of a case addressed to him. This avoids much loss of time, and the patient is at once provided for in every manner. When no attending physician has been selected, and this is left to the physician in charge, the latter makes the selection according to his best judgment.

To the public it furnishes a home where proper care can be obtained when it is most needed, and that at no greater expense than incurred during health. Nothing can be more unfortunate than to be sick in a boarding-house or a hotel, and to this are exposed one-fourth of the population of this city, and the majority of travelers and strangers who are constantly in our midst. Such an institution is of great value to these, for in case of illness they can obtain the care necessary to their condition, thus avoiding the indifferent and expensive attentions of hotel or boarding-house nurses. They can be attended by their own physician, or by one recommended by a friend, provided that this physician be a regular graduate.

It is also a convenient home for incurables and chronic cases, where a physician may at a moment's notice be required; apartments are reserved for these, apart from those devoted to transient patients. We make these remarks apropos of the opening of such an establishment in Philadelphia, under very competent authority. The location of this *Maison de Santé* is No. 351 Spruce street, within easy access of the cen-

tral portion of the city, and its charges, $7 per week and upward (according to accommodations), place it within the reach of all classes of society.

Dr. Chas. E. Sajous, the physician in charge, was at one time connected with a like institution in San Francisco, Cal., of late House Physician of Howard Hospital, and now in the Laryngoscopic Department of Jefferson College Hospital. His office is at No. 1010 Walnut street, where communications should be addressed. There is also a resident physician.

The plan of the *Maison de Santé* recommends itself to the profession, and it is to be hoped it will meet the success of which it is worthy.

Notes and Comments.

Enlargement of the "Reporter."

It gives us great pleasure to announce that from and after January 1st, next, the Reporter will be *enlarged eight additional pages*, and will give in every issue twenty-six to twenty-eight pages of reading matter. The increasing quantity of valuable material offered for publication, and the constantly widening interests of the medical profession, have shown us that our present limits are too contracted. We wish to represent fully all sides of professional life, the hospital, the laboratory, the medical society, the library, and the daily calls of the doctor. Hereafter we shall have space to do it.

We have arranged to fill these additional pages with superior material, and such as has interest to physicians wherever located. Well digested reports on the progress of special branches of medicine, abstracts of the leading society meetings, and more ample clinical and hospital reports will be secured. In addition to that, we are planning some novel and entertaining features of medical journalism, in which all readers will be interested, and the details of which we will announce later.

We trust that all our present subscribers will continue with us, and many new ones join their ranks.

Intra-Uterine Injection of Antiseptic Solutions.

Dr. Rendu, in a paper in the *Progrès Médical*, October 9th, quoted in *Centralblatt für Gynækologie*, asserts, that intra-uterine injections are without danger; that the liquid never penetrates into the peritoneal cavity by the fallopian tubes, except when injected with very considerable force; and that hemorrhage does not follow such injections. Most of the great French accoucheurs with whom the author has communicated are in favor of such injections used as means of prophylaxis, but only after instrumental or complicated labor.

Intra uterine injections should then be made, when the labor has been tedious or instruments have been used; when there is total or partial retention of the placenta; and again, when, after hemorrhage or other accident, the lochial discharge becomes fetid. But it must be remembered, that Küstner, Fritsch and Herdegen, have reported cases where intra-uterine injection was followed by immediate, grave and even mortal accidents; and Fritsch advises, in consequence, that the current of liquid should be directed slowly against the inner walls of the uterus, and that there should be no obstacle to its free exit.

Dangers of "Bonwill's Method" of Anæsthesia.

This method, as is well known, is by means of forced respirations. Dr. Henry Gibbons, of San Francisco, says of it, in the *Pacific Medical Journal*:—

"We suppose that most persons, most boys, at any rate, have experienced the sensation produced by blowing at a fire, substituting their lungs for a bellows. The proposed method is nothing more than an exaggeration of this. So far from regarding it as likely to prove useful, we look upon it as decidedly dangerous. It puts the brain in an abnormal condition, by interfering with the circulation, and is almost equivalent to partial strangulation. We are surprised that any considerate physician should recommend such a violation of physiological laws."

Perfumed Carbolic Acid.

℞.	Acidi carbol. cryst.,	1 part
	Olei limonum,	3 parts
	Alcoholis (36°),	100 parts. M.

This mixture, which appears to be quite stable and has only the odor of lemon, is what has been known as 'Lebon's perfumed carbolic acid', the formula for which has long been a secret, but has now been made known in the *Moniteur Scientifique* of Paris. The antiseptic properties are in no way affected by the oil of lemon.

Headache in School Children.

A recent writer, Dr. Treichler, states that about one-third of the pupils in schools suffer more or less from headache. It leads to poor-

ness of blood, and loss of cheerfulness and mental energy. Its chief cause is probably overwork, and especially nocturnal study. The anatomical changes which accompany the more advanced stages of this habitual headache are, in the author's opinion: 1. Trophic changes in the ganglion-cells of the brain cortex, caused by anæmia. An anæmic brain is much more easily exhausted by mental exertion than a normal one. 2. Passive dilatation of the cerebral blood-vessels and consequent stasis; the perivascular spaces round the capillaries become narrowed, the removal of waste products is thus hindered, and in this way again trophic disturbance is caused. Recent views, which regard progressive paralysis as commencing by vaso motor trophic changes in the brain-cortex, paretic dilation of the vessels of the pia mater, and degeneration of the cortex through lymph-stasis, increase the significance and importance of the conditions believed by the author to be brought about by prolonged habitual headache in young people.

Causes of Diphtheria and Typhoid.

Dr. Edward M. Snow, in his last report as City Registrar of Providence, observes:—

With regard to the causes of diphtheria and typhoid fever, in cities, they are well understood; indeed, it may be said that they are positively known at the present time. They are impure air or impure water, the impure air generally arising from collection of sink water or from privy vaults. These are causes that can be prevented or avoided in nearly all cases; they are causes that, in cities, almost without exception, exist in the houses or in the immediate proximity of the houses where the diseases are found. If these causes are allowed to remain in or about any house, cases of diphtheria or of typhoid fever, in their season, may be expected to appear in the same house. The converse is also true, that if cases of diphtheria or of typhoid fever do exist in any house, it is proof positive that the causes of the disease also exist in the same house. There are good reasons for believing that, to some extent at least, scarlatina depends upon the same causes for its propagation.

Who is responsible?

Influence of Race on Insanity.

What influence race has on insanity has recently been studied by Dr. Spitzka (*Journal of Mental and Nervous Disease*). His conclusions are, that, on the whole, the different forms of insanity occur in nearly the same proportions in the Anglo-Saxon, Teutonic, Celtic, and Hebrew races; paralytic insanity is most common among Anglo-Saxons and least common among Negroes; melancholia is most common among Germanic peoples; the tendency to terminal dementia is greater in the Anglo-Saxon than in the German or Celt; and the forms dependent upon hereditary taint are most common among Hebrews. With this it is in accord, that since the termination in dementia and the influence of heredity are the factors which chiefly cause an accumulation of the insane population, the Hebrew and the Anglo-Saxon should have the highest proportions insane of their respective populations.

Northern Georgia as a Resort for Consumptives.

This part of the South has for years had considerable credit as a resort for the phthisical. A late study of it has been made by Dr. H. P. Gatchell, of Atlanta, in the course of which he asserts that, so far as statistics indicate, no other so favorable place of resort for the consumptive is to be found in the whole country; and his experience in the treatment of patients there goes to confirm the conclusion derived from statistics. He has had those who had tried Florida and other Gulf lowlands before visiting this region, as well as those who had come directly from the North. His son, who has had extensive experience in the treatment of pulmonary diseases in Colorado, holds the same opinion of the merits of this region. The subject of consumption formerly, he has tried Texas as well as Colorado. He finds himself in better health in Georgia than in any other place in which he has lived.

Faradizing the Spleen in Ague.

It is mentioned in the London *Medical Record* that Dr. Schröder, of St. Petersburg, in forty two cases of intermittent fever, some of which were old, and in most of which the usual medication had proved of little use, got almost uniform success by faradizing the spleen. The method used was to hold an electrode *in situ* on the left hypochondrium, while the other was carried slowly along the edges of the enlarged spleen. An application of five minutes every day sufficed.

Chloral as an Anæsthetic for Children.

M. Redier, in an article in the *Journal des Sc. Medic. de Lillé* asserts that he has found that young children support, even better than adults,

chloral at the dose of 60 to 75 grains per diem. He confirms M. Bouchut's assertion that chloral, given so as to induce sleep about one hour and a half before the operation, acts efficiently as an anæsthetic in any of the minor operations (extraction of a tooth, application of actual cautery, opening of abscess); indeed, M. Bouchut contends that forcible straightening of an ankylosed joint may thus be performed; and an operation for hare-lip has been performed in a child of six, after administration of 60 grains of choral.

Higher Mortality in Valleys.

In the course of an article in the Atlanta *Medical and Surgical Journal*, October, Dr. H. P. Gatchell observes:—

In supervising the census of North Georgia, I have had ample confirmation of an observation which I long since made, of the increased ratio of mortality in narrow valleys. Such valleys, especially in mountainous countries, are hotter by day and colder by night than more open areas. The nights, too, are characterized by dense fogs, which contribute to render the cold night air more chilling. What with the confined air and the heat by day, and the chilly dampness of night, the mortality from both fevers and consumption is increased.

Beef and Bitters.

A correspondent writes to the *Maryland Medical Journal* that he has found from personal experience that the unpleasantness of the sulphate of quinia (which prevents the prescribing of that very valuable drug in many cases where no other remedy will take its place) is materially obviated by the addition of Liebig's Liquid Beef. The beef taken before quinine also seems to have a tendency toward preparing the stomach for its reception.

Purgatives in Phthisis.

M. Ferrand, in his clinical lectures on phthisis, recommends that the following mixture should be administered in a cup of tea when it is necessary to relieve constipation in phthisical patients:—

Calcined magnesia,	2 to 4 grams
Manna in tears,	30 to 40 grams.

If this laxative has to be taken often, it may be converted into an electuary by the addition of a little honey. In this form a large spoonful is to be taken every morning.

Manna in tears,	30 grams
Calcined magnesia,	4 grams
White honey,	30 grams.

Correspondence.

An Interesting Pulmonary Case.

Ed. Med. and Surg. Reporter:—

Allow me to give the history of a very interesting case.

J. P. A., aged thirty-four years, received an injury in the region of the spine while traveling over the Baltimore and Ohio Railroad, in March, 1853. Came home and suffered for some time, hoping to recover without medical aid, he being a stout, robust young man. He finally called a physician, who pronounced it abscess of the lung, and treated him for that. After a time he recovered sufficiently to attend to business, but was unable to do manual labor. From this time on he spat up large quantities of sputa.

In November, 1862, he went to the woods, gunning, and by accident fell, striking his back on the log he was standing on; this disabled him so that he was scarcely able to get home. He was then treated for pleuro-pneumonia, rallied, and was again able to attend to business. Being a man of considerable talent, he was elected to a county office, which he filled acceptably; he was afterward elected Justice of the Peace, which office he held until his death. About three years before his death he coughed up several spiculæ of bone. All this time he had been discharging large quantities of sputa—as much as a quart—morning and evening, beside what was expectorated during the day and night. He died November 4th, 1880.

A post-mortem, held on the 5th, by Drs. Trimble, Holtz, and myself, showed the left lung with lower half tuberculous and solidified; upper portion almost normal; heart slightly atrophied. Right lung adhered to the ribs its entire border. On removing it, found the cells entirely destroyed, and full of tuberculous matter. On examination of the cavity, found necrosis of the vertebra for about six inches, and extending along the ribs for perhaps four inches. There was a large quantity of bone spiculæ, large and small, lying loose in this cavity, and a large number adhered to the lung.

The query to me now is, why did not any of the attending physicians diagnose disease of the spine during life, and why did they all agree that the disease was on the left side instead of the right? Was it because he always lay on the right side when he discharged such large quantities of sputa?

E. K. Strawn, M.D.

Hendrysburg, Ohio.

Case of Imperforate Anus.

Ed. Med. and Surg. Reporter:—

In March, 1879, Mrs. W. was delivered of her fourth child, a boy, strong and healthy, weighing nine pounds. On the second day after birth the nurse informed me the child had had no passage from the bowels, and seemed uneasy from that cause. Made an examination, and found the child entirely destitute of any anal orifice, there being no mark or sign to show where it should be. The child passed his urine freely,

and with it meconium in considerable quantities, showing that the intestine ended in the bladder, or urethra. An incision was carefully made in the median line, passing through the tissues for half an inch, the finger was then pushed up cautiously, but no intestine could be felt. The third day passed with no change; the fourth morning the abdomen was very much enlarged, fecal matter in quantities was passed through the penis, and the patient was evidently in great distress. A sharp-pointed bistoury was guarded, except at the point, the forefinger of the left hand inserted into the cut as far as possible, and the bistoury carried up on its surface beyond the end, and a cutting motion made. Some fluid was felt on the finger, which, on removal, appeared to be matter. An oiled rag was introduced into the outside opening. In a few hours the plug was taken away, and was followed by a copious evacuation. The child was relieved, and continued to thrive. The artificial opening was kept distended by the introduction of the finger occasionally, the edges healed kindly, and turned in with appropriate puckers, as a rational anus should, and the sphincter continues to act in a normal manner. The boy is now a year and a half old, in good health. He has had several attacks of diarrhœa during the summer, and whenever he had much tenesmus or straining fecal matter passed through the urethra. The connection does not seem to be in the bladder, as no urine ever escapes into the rectum, but appears, from some late examination, to be below the neck or in the region of the prostate, and to be valvular.

The question of interest arises, where the membrane came from to form the rectum, which seemed to be entirely wanting. The cellular tissue must have taken up a new action, and one have been formed of it, as all the attributes of anus and rectum are now present.

Clinton, Iowa. P. J. Farnsworth, M.D.

How Long Does Gonorrhœal Virus Retain its Potency on Dry and Inanimate Surfaces?

Ed. Med. and Surg. Reporter:—

On the 17th of July last a young man, by occupation a blacksmith, came to see me, with a reddened meatus urinarius and a slight discharge therefrom. He gave the following history, which I believe to be strictly true. He became acquainted with a young lady visiting in this village, and was "invited to call." The invitation was accepted July 13, and also another invitation of a *different character* the same evening. This was the first and the *last* time that he had ever had sexual intercourse. At first he improved under treatment, but every few days he would be worse. This condition of affairs continued until August 1st, when he went to Saratoga Springs. At the end of the first week he wrote me that he was *well*. He returned at the close of another week and resumed his vocation, but no sooner was he at work than trouble began again. He remained at work and continued treatment until I was nearly at my wits' end to know what next to do, when the discharge ceased. This was about two weeks ago. This delightful period (to him as well as myself) lasted five days, when he had all the symptoms of a recent infection. I prescribed as I would for a recent case, and at the end of three days the horizon was clear again. This evening he came in, which is three or four days since the discharge ceased; said he had found out the trouble, and felt positive the end had come. When first taken he got some of the discharge on his pants, and now, when he comes to think of it, remembers that whenever he wore those pants, and was well enough to do without the wrappings, he would get worse again.

If this be the case, and I doubt not it is, then why are our text-books so reticent concerning the danger of infection from this source, water-closets, etc.? E. T. Rulison, M.D.

Amsterdam, N. Y., Nov. 8th, 1880.

News and Miscellany.

The Marine Hospital Service.

The annual report for 1880, of this valuable branch of the public service, contains a number of interesting statistics relating to the medical care of the merchant marine of our country. It shows that while the number of patients in 1869 was only 11,356, which were treated at a cost of $406,089, the 24,860 sick seamen taken care of by the service last year required an expenditure of only $402,185. The relation of the total cost to the number of patients is shown by the average per capita cost, which has been reduced, by degrees, from $38.41, in 1870, to $16.18, in 1880. These gratifying results are attributed chiefly to the fact that the appointment and promotion of medical officers of the service, upon whose professional skill, fitness and faithfulness its character and conduct, of course, largely depend, have been removed from the influence of politics. As the current fund, from which the expenses of the service are defrayed, is the property of the seamen, and simply managed *in trust* by the government, this is as it should be.

The establishment of additional hospitals at several of the largest ports is recommended by the Surgeon General, and, as in the past it has shown that the best results in all respects are obtained at those relief stations where the service controls its own hospitals, it is to be hoped that the recommendation will be heeded, especially as the administration of the affairs of the service has been so satisfactory.

Septics and Antiseptics.

The following incident was related by Dr. W. H. Hingston, Professor of Surgery in the Montreal Medical College, in a recent address:—

A strong impression as to the little value of the antiseptic in recent wounds was made on my mind on the occasion of my last visit to Europe. Syme and Simpson, Edinburgh's greatest teachers, were living at the time. The latter invited me to be present when he removed a breast. Before the operation was begun, he said to me: "Come every day, and see how this case gets on

—I promise you there will not be one drop of pus!" I am free to admit I thought the promise a bold one. I visited the case till union was complete; and, as had been promised. "not one drop of pus" was formed. At about the same time I saw Mr. Syme perform on the foot the operation which bears his name. It is needless to say it was well done, and with antiseptic precautions. But before the integument was sutured, it was perforated at the most dependent part, and a piece of lint, soaked in carbolic acid and linseed oil, was put through it. I ventured to ask Mr. Syme what that was for. "To permit the escape of pus," was the reply. "Then you expect pus, Mr. Syme?" "Certainly," was the answer. This promise also was fulfilled, and pus did form. Their two modes of operating impressed me strongly, but not in the same manner. Simpson's method, as on the occasion referred to, has influenced my practice ever since.

Growing Importance of Veterinary Medicine.

As we predicted last year, the very great importance of veterinary medicine to the health and prosperity of the community is being rapidly recognized. We note that on November 17th, at a meeting of the stock raisers and men interested in stock and in the commercial interests of the West, who represented and spoke for a trade which amounts to hundreds of millions of dollars annually, the following resolutions were adopted:—

Resolved, That it is an imperative duty of Congress to enact such a law as shall effectually prevent the spread of this disease into States not already infected, and which shall result in its entire extermination at the earliest practicable date.

Resolved, That as the important preliminary step, we heartily second the recommendation made by Judge Jones, of Ohio, to the President of the United States, for the appointment of one or more veterinary inspectors, who shall definitely ascertain and designate the infected regions.

Not only is this a matter in the first rank of importance for its economical bearings, but also as it affects the health of our population. Energetic measures must be taken to prevent the spread of diseases of animals used for food, and that soon.

Difference in the Estimate of Longevity.

A writer in the last number of *The American*, speaking of longevity, observes that there is one point which is too frequently overlooked by writers on historical cases of longevity—the singular difference between our estimation of an old man and that of our forefathers. "Old John of Gaunt, time-honored Lancaster," died at fifty-nine, so did James I; Henry VII only reached fifty-three. The Huguenot Admiral, Coligny, whose "hoary hair, all dabbled o'er with blood," is mentioned by Macaulay, and whom his earlier biographer, Lord Huntington, represents as a very old man. was slain at fifty-three, when, in these days of Moltkes, Gortschakoffs, Gladstones, Beaconsfields, Dufaures, Broughams, and Lyndhursts, a man is supposed to be rather on the juvenile side. In point of fact, for our ancestors, a man of fifty was old; with us, the limit is nearer eighty. It is legitimately to be inferred from this fact—in the first place—that the average duration of human life was shorter in past time than it is nowadays; in the second, that the chances of error in accounts of alleged centenarians were infinitely greater—that if a man of eighty or eighty-five called himself one hundred or one hundred-and-ten, his story would be exceedingly apt to be believed.

Burning of the Minnesota Insane Asylum.

On a freezing night last week the magnificent building of the Minnesota Insane Asylum caught fire from its gasoline works, and a large portion of it burned to the ground. Of the patients it is found that thirty are missing. Of these only six are known to be dead and their bodies have been recovered. Among others reported to be dead are Dr. S. S. Pruden, of Lake City; but there is nothing certain about his fate. The missing victims not killed are supposed to be wandering about the country. The number of dead may be increased by freezing. All records of patients in the male department were destroyed, necessitating the personal identification of over five hundred patients.

Items.

The Philadelphia Dispensary for Skin Diseases has removed from 216 South Eleventh street to 1021 Lombard street.

QUERIES AND REPLIES.

Dr. F. writes: Will you please publish in your Queries and Replies what you regard as the best formula for a combination of strychnia, phosphorus, and iron. This may seem a simple question, but I think it would be of value to many physicians, judging from some prescriptions I have seen. I mean a prescription that will include the ordinary doses of each article and make the combination as palatable as possible.

Ans.—It were easy to suggest several such combinations, but we prefer asking our readers to send us a few formulæ which their experience has approved.

Dr. J. L. G., of Ark. Please write us for what the instrument referred to is used? Do you mean Doisneau's apparatus?

Dr. S. L. P., of O. External biliary fistulæ are extremely rare. Legg, in his late work on the bile, reports only one case in which pure human bile has been examined by this means. Dr. G. W. H. Kemper gives some instances in the *Trans. of the Indiana State Med. Soc.*, 1879.

MARRIAGE.

BARTLETT—MOORE.—On Wednesday, Nov. 17th, 1880, at Grace Church, Brooklyn, N. Y., by the Rev. James W. Bradin, Rector of St. Paul's Church, Flatbush, Homer L. Bartlett, M.D., of Flatbush, Long Island, and Sarah Forde Moore, of Belfast, Ireland.

DEATH.

GALLOWAY.—At Lindale, Clermont County, O., of phthisis, Maria S. Coombs, wife of Dr. J. S. Galloway, aged 47 years.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1240.] PHILADELPHIA, DECEMBER 4, 1880. [Vol. XLIII.—No. 23.

Original Department.

Lecture.

SCARLATINA.

Delivered in the Jefferson Medical College,

BY WILLIAM B. ATKINSON, A.M., M.D.,

Lecturer on Diseases of Children.

Synonyms.—Scarlet fever; scarlet rash.

It is of much importance to know that these are but other names for this affection, and that they are equally powerful to act as points of contagion for the most malignant attacks of the disease. I am the more particular to mention this point because among the profession, as well as among the people, you will constantly find the mistake made that scarlatina is merely a mild form of the disease, and that scarlet rash is only a disease resembling the fever, but of little importance. I urge you, in every case of scarlatina, to make the nature of the disease fully known, and to insist upon the necessity for the same precautions as in the most malignant form. By such precautions, I mean care as to the exposure of others, and care to avoid those dangers which we are so likely to see following in the train of this much dreaded disease.

Symptoms.—Premonitory symptoms are often so slight as to escape notice. The febrile symptoms set in very abruptly, and usually with great severity; the delirium in many cases is marked, or the patient lapses into a state of stupor more or less profound.

The earliest symptom which almost invariably presents itself is a severe attack of vomiting, which is more noticeable by the absence of the usual causes; the patient, when of sufficient age, being sure that nothing has been eaten which would be likely to induce such an attack.

This rarely occurs after the first twenty-four hours, and does not continue.

Along with the usual febrile symptoms, which increase toward night and remit toward morning, there occurs a sore throat, which appears with equal suddenness, and generally is very annoying, so as to interfere greatly with deglutition. In examining the throat, the attention will be attracted by what is known as the "strawberry tongue," caused by the papillæ projecting like bright red points on its surface; and the breath is peculiarly hot.

The pulse is extremely rapid, usually reaching above twice the normal rate; the face is flushed; the temperature ranges high from the outset, say one hundred and three degrees Fahrenheit; restlessness is marked, and headache frequently is much complained of.

By the end of the first day the eruption commences, in the form of a fine efflorescence; making its appearance first on or about the neck and upper part of the trunk, in patches which rapidly unite and form a bright, scarlet surface, speedily extending over the whole of the body, reaching the legs and feet last. This rash is almost precisely similar to that which ensues from the application of mustard or heat to the skin. Pressure causes its temporary disappearance, but on removal of the pressure the rash speedily returns. Occasionally the eruption assumes the form of numerous slight elevations, causing a feeling of roughness, or they may form papulæ, in which case the disease is called *scarlatina papulosa.* Some authors mention instances where the eruption appears

like large vesicles filled with a muddy fluid. Along with the rash comes a tingling or burning of the skin, which shortly changes to an irritable itching as the eruption declines. Up to this time the patient exhibits a peculiar want of energy, which now disappears.

These symptoms continue with much sameness for five or even six days, when they begin to decline. The rash gradually fades, the fever lessens, the child shows by its general demeanor that its system is recovering from the first effects of the attack. Desquamation now begins, and takes place in the same order as the eruption occurred. It must be remembered that this is the critical period; first, because it is the time when the disease is most capable of being conveyed to others, and again, because, without the utmost care, the child is exposed to dangerous sequelæ. This process of desquamation varies as the severity of the attack, from an exfoliation of fine scales, to the peeling off of the outer skin in large scales, flakes, or patches; and from the hands and feet like portions of a torn glove or shoe.

This description is presented as that of a typical form of scarlet fever, and may vary greatly in intensity and in the order of the phenomena.

Thus the attack may be so slight that the child continues at its play, and really presents so few evidences of the presence of disease that its dread nature is only shown by the occurrence of anarsaca, rheumatism, or other form of sequel. Or, the disease poison may expend its force on the throat, and the disease is then termed the anginose form, or *scarlatina anginosa.* In these cases the ordinary symptoms are usually present in the mild form, but from the outset the throat is much inflamed, the inflammation extending to the prolongations of the mucous membrane into the Eustachian tube, to the internal ear; through the posterior nasal passages up into the cavity of the nose; deglutition becomes almost impossible, fluids being returned through the nose; hearing is greatly impaired; finally, the glands and the cellular tissue of the neck become involved, and by the great swelling that results the patient's neck appears as if encircled with a "collar of brawn."

Should the symptoms continue, ulceration and sloughing ensue, which generally end in death by the opening of an important vessel or by exhaustion.

Cases have been observed where no rash appeared.

Another form is that known as the malignant type, or *scarlatina maligna.* The symptoms are all aggravated. Profound coma may set in and end in death in a few hours. Or the fever is of great violence from its inception; the delirium marked; restlessness extreme; speedily followed by great and rapid exhaustion and death. Where the progress is not so rapid the rash is of a dark purplish hue; when pressure is made the color is slow to return, evincing a very sluggish condition of the blood; the heat is excessive from the first until near the close, when the approach of death is heralded by a cold, clammy condition of the skin; the pulse ranges high, running up to 150 or 160. Death frequently closes the scene in two to four days, but if the case is prolonged, severe pharyngeal inflammation sets in, followed by ulceration, sloughing and exhaustion.

Other symptoms may occur, of greater or less significance. Thus, many cases, even of a mild form, may be ushered in by a convulsive attack. Here the convulsion is quickly followed by the usual symptoms of the disease, and does not recur. When it does return, or is followed by coma or great depression, the prognosis is doubtful. Especially is this the case when convulsion occur after the eruption has been fully developed. We have the best reason to regard this as a fatal symptom. Diphtheritic deposits may take place upon the inflamed throat, and always add to the gravity of the attack.

The *period of incubation* of scarlet fever is about from three to six days, but occasionally it would seem as though the poison may remain dormant in the system for a very long period; one authority gives forty days. The author has known one case where it extended to at least twenty-eight days.

The symptoms which may be regarded as unfavorable are prolonged coma, recurrence of convulsions, great delirium, drowsiness, with convulsive twitchings, a dark red or dusky eruption, continuance of very high temperature (105° being considered by some as a fatal sign), coldness of the extremities while the trunk remains very hot, renewal or continuance of vomiting, profuse discharges from the bowels, severe any nose affection, the occurrence of abscess of the throat, or the evidence of exhaustion, as shown by a rapid, feeble pulse, panting respiration, etc. But under all circumstances the prognosis must be guarded, as grave changes occur with little or no premonition and with great suddenness.

The *differential diagnosis* between this and diseases of similar appearance is usually readily made by the suddenness of seizure, vomiting

rapid pulse, pungent and great heat, strawberry tongue, redness of fauces. The absence of the usual sneezing, coryza, etc. would not cause it to be confounded with measles; the absence of backache and frontal headache would eliminate variola.

Before the eruption appears a very early symptom is a general redness of the middle of the soft palate. Alois Monti says that this may be confined to the uvula, or extend to the anterior faucial pillars and the tonsils, but never to the posterior wall of the pharynx alone, as in smallpox; and in measles the redness of the posterior walls is always greater than that of the anterior. Again, there is no swelling of the parts for the first few hours, as we find in the tonsils in measles. Haviland Hall says that a peculiar punctiform appearance may be noted in the fauces, even ten or twelve hours prior to the cutaneous eruption. This author quotes Dr. Joseph Duggan, of Ireland, as insisting upon a very early pathognomonic symptom; a peculiar, brilliant and glistening stare of the eye, quite the reverse of the watery eye of measles. The eruption in all eruptive diseases generally appears first in the mouth and on its roof, and here the rash of scarlet fever would present its distinctive features of a bright scarlet hue without prominence, disappearing temporarily on pressure.

After the eruption appears, the disease can only be confounded with rötheln or measles. In the first it appears almost simultaneously over the whole body; in scarlet fever it appears on the second day, and extends from the neck to the face, body, and then to the limbs; in measles it appears on the fourth day on the face, and gradually spreads.

The eruption of scarlet fever is uniformly scarlet red, occasionally in large patches, which speedily coalesce without elevation, and disappears temporarily on pressure; the eruption of measles consists of patches of spots like fleabites; darker red, more like the raspberry color, elevated slightly, and the patches have a tendency to assume a half moon or horse-shoe shape; the rash of rötheln is more like measles in color and shape, but occasionally appears like an efflorescence. Here the diagnosis would be made by the speedy fading of the eruption, and the absence of other scarlatina symptoms.

In making the diagnosis the history and surroundings of each case must always be taken into consideration; thus, if the patient have suffered from any previous eruptive fevers, and the fact of the existence or exposure of the patient to any form of disease.

This disease may be either complicated with or followed by a number of conditions. Chief among these is dropsy, which is often due to an inflammation of the kidneys and is associated with albuminuria. The symptoms which indicate the presence of this complication are serous effusions, generally in the limbs, face or abdomen, more rarely into the lungs, the pleural cavity, the pericardium, or into the submucous tissues of the larynx; a renewal of the fever and restlessness, etc. The quantity of the effusion varies, and with it the gravity of the symptoms. When in small amount, and not in important cavities, it is readily thrown off, and the patient goes on to complete recovery. Death speedily ensues, often within a few hours, when the effusion is intracranial, within the lungs, the glottis, the pericardium, or the pleural cavity. Accompanying and grave symptoms are scanty or entirely suppressed urine, headache, vomiting, convulsions and coma.

In the absence of these symptoms, even with the presence of the effusion in a non-vital locality, the prognosis is favorable, with the expectation of a complete disappearance of the dropsy in from two to four weeks.

Although the grave symptoms above mentioned are generally due to the direct poisonous action of the scarlatina virus upon the kidneys, yet in many cases the liability to these complications is greatly increased by exposure to cold or dampness during the period of desquamation; and this most frequently occurs where the attack has been of a mild form, either from ignorance of the presence of the dangerous malady, or from neglect, under the impression that the attack has been too slight to need any care.

Diseases of the ear and consequent deafness are common sequelæ of scarlet fever. In extreme cases the inflammation may extend to the mastoid cells, and even fatal meningitis may finally occur.

Rheumatism of the joints, more or less acute, is very frequently seen to occur during convalescence, and is the result of exposure to dampness or cold, especially after a very mild attack. The pain is usually very annoying, but the redness and swelling are slight.

Occasionally, there are abscesses of or around the parotid and other glands of the neck, or great loss of substance by abscess, or sloughing of the throat.

In rare instances female children have been attacked with inflammation of the vagina, followed by a profuse leucorrhœal discharge, and of a very intractable character.

The intensity of the attack varies, not only in each epidemic, but according to the strength of the patient. As a general rule, weak children are more severely attacked.

Prophylaxis.—Beyond all else is isolation and thorough disinfection of the apartments occupied by the sick, as well as everything carried from them. Clothing, rags, etc., should be burned at once, or if too valuable to be destroyed, should be exposed immediately to a temperature not short of 212° Fahr. Free ventilation of the sick room is eminently required; this aids greatly in diluting, if not in driving out, the poison, and also prevents the unpleasant, perhaps injurious, effects of many articles used as disinfectants.

Many of the common people, and we may include not a few physicians, seem to believe that the efficacy of a disinfectant depends upon the amount of abominable odor that it is capable of giving forth. Hence, chloride of lime, carbolic acid, asafœtida, in fact any ill-smelling article is preferred by them as a disinfectant. We believe that disinfection of the discharges, of whatsoever kind, and the prevention of the dissemination of the exfoliations from the skin, will absolutely do all that can be done. Perhaps for this latter purpose we have nothing better than inunction.

Prophylactic medication is yet *sub judice*. The lecturer has, in a number of instances, employed sulpho-carbolate of sodium, and with such apparently good results that he proposes to continue it until convinced that it is useless.

Treatment.—In every case of this disease, whether mild or malignant, much depends upon the care and attention of those who are to act as nurses. The efforts of the physician must be directed to the relief of urgent symptoms, as intense febrile action, the prevention of debility, and of complications.

The patient should be kept in bed in a well-ventilated room, with especial care to avoid the slightest exposure to a draught. In ordinary cases the medicinal treatment will be limited to the meeting of indications as they arise; the patient should be allowed cool, acidulated drinks, and plain, easily digested food. Sponging the whole surface with tepid water is in many cases very comforting. The same effect is produced by the process of inunction. The usual domestic remedy is pure lard, or the fat of bacon. Preferable is the unguentum petrolei or "cosmoline," and where the itching is very annoying, it is better to employ the carbolated preparation, which contains three per cent. of carbolic acid. The inunction should be repeated at intervals, as circumstances demand, to relieve the dryness and mitigate the great heat of the skin.

The physician must constantly keep in view the tendency to depression, and remember that stimulants are to be employed at the earliest indication of debility. Preparations containing chlorine in some form have long been favorites with the profession, under the belief that this article acts to destroy the poison of the disease. Watson, in his Principles and Practice of Physic, gives this formula: "Put eight grains of the chlorate of potassa into a pint bottle, and pour upon them one drachm of strong hydrochloric acid. Keep the mouth of the bottle closed until the violent action has ceased; then add an ounce of water, and shake the mixture well; then add another ounce of water, and again agitate well; and so on, until the bottle is full. The chlorate should be pulverized, and in cold weather the bottle should first be warmed. A tablespoonful or two of this mixture, according to the age of the patient, may be given for a dose, frequently. An adult may take the whole pint in a day."

At present, many practitioners employ a formula containing the chlorate of potassa and the tincture of chloride of iron, regarding this combination as of great value, also, to meet the throat symptoms. When needed, the throat may also be gargled with this combination in honey and water. For the great restlessness the bromide of potassium, or of sodium, will be found valuable in moderate doses, repeated at intervals of an hour or two, until quiet is produced.

Many authorities agree that in consideration of the poisoned condition of the blood, small doses of carbonate of ammonia should be given every two or three hours.

J. Lewis Smith gives the following:—

℞. Ammon. carb., Ferri et ammon. citrat., āā ℥ss
Syrup. simplic., f.℥iv. M.

One or two teaspoonfuls every two or three hours.

Some prefer the liquor ammoniæ acetatis, and this, in all cases, should be employed with an excess of the ammonia.

Should the symptoms indicate exhaustion, with the decline of the eruption, quinine should be employed, as also the carbonate of ammonia.

In my own experience, no single remedy has given me such good and such constant results as *digitalis*. About the year 1858 the late Dr. Lewis P. Gebhard read a paper before one of our medical societies, very strongly advocating the use of this article in all the forms of this

disease, and claiming for it the character of a specific. His method was to put one drachm of the powdered leaves of digitalis to twelve tablespoonfuls of boiling water, and when the infusion had cooled, to give it in teaspoonful doses every hour or two, according to the age of the child and the gravity of the symptoms. Since that time I have used it in a large number of cases and with the best results. I generally order it prepared in the same way, and direct the nurse to give it in teaspoonful doses every hour or two, until the pulse and temperature are positively reduced; then to lengthen the interval, so as to maintain the effect thus obtained. I believe that I have almost invariably observed the symptoms to moderate within from twelve to twenty-four hours, and I feel confident that while I have never in a single instance known any of the so-called poisonous effects of the remedy to follow, I have also failed to see the usual dangerous sequela in many cases, and only slightly in any. I have never seen anything to warrant a belief in its usually dreaded "*cumulative effect.*"

Prof. Bartholow says the antipyretic effect of digitalis is much insisted on in Germany. "In scarlet fever its utility is very great; it lowers the temperature, and maintains the action of the kidneys, thus obviating the two principal sources of danger in that disease." He gives a drop or two of the tincture every hour or two, according to the age, in a little water, or from half a teaspoonful to a teaspoonful every two, three, or four hours.

He further says, that in a considerable experience in the treatment of this disease he has found digitalis uniformly successful, and taking in a group the ordinary cases of scarlatina simplex and scarlatina anginosa, it is the most efficient remedy we possess.

Dr. Sydney Fennel has used it largely in scarlet fever, and finds, when administered early in the fever, the inflammatory action of the glands of the neck subsides gradually. The fever leaves the patient in the usual time, desquamation is slight and the chances of chronic nephritis are reduced to a minimum. He also confidently asserts that the infectious character of the disease is lessened by the remedy, if not destroyed (*Lancet*, Jan. 23d, 1869).

Nearly all recent authors agree as to the value of digitalis in the dropsy following this affection. If they would but employ it from the inception of the disease, they would rarely or ever see any such sequel.

Dr. Lewis Smith ("Diseases of Children") says: "Digitalis will often be found useful, as a heart tonic, when the pulse is rapid and weak. One teaspoonful of the infusion, or four or five drops of the tincture, may be given every four hours, to a child of five years."

The late Prof. Geo. B. Wood says: "I have found great apparent advantage, in cases attended with a very frequent pulse, from the use of tincture of digitalis."

In my own experience, I have been deeply impressed with the certainty and promptness with which this symptom would be relieved. It must be remembered that the remarkable frequency of the pulse is a prominent symptom.

Before leaving this portion of the subject, I would most earnestly urge upon the profession a fair trial of this remedy, remembering that such a test requires the employment of a good quality of the drug, and its administration with as much care and observation as any other form of remedy. In my own practice I carefully instruct the nurse as to its preparation, how to give it, and then what is to be expected as to its results.

The sequelæ of this disease and their treatment will form the subject of another lecture.

Communications.

OUR PHYSICIANS AND PREACHERS.

BY REV. E. B. RAFFENSPERGER,
Of Philadelphia.

These two classes of public benefactors are frequently compelled to work in unison. Ordinarily they are by no means disposed to quarrel with each other, and in the habit even of showing to each other pleasant courtesies. But there are times when a spirit of antagonism appears between the members of these learned professions, and they disgrace themselves in the presence of a disgusted public by doing or saying those things concerning each other that are both unseemly and unjustifiable. The writer of this article happens to be a minister, but a constant reader, for several years past, of your valuable Reporter. In early life his tastes drew him toward the medical profession, and while passing through his collegiate and theological training at Princeton, he enjoyed the rare privilege, during his vacations, of listening to the celebrated lecturers in the great schools of medicine in Philadelphia and New York. His opportunities in this line gave him a deep interest in that branch of science. In subsequent years his experience as pastor furnished him with practical exemplifications of the relation of the physician to the

preacher. Among his most valued friends and co-workers in the ministry have been men skilled in the healing art. With the exception of about a year, during his whole life as a pastor, he has had one or more physicians in his congregation, and his relations to these men have been very pleasant. It is a singular fact that during the twelve months referred to he was called on less frequently than usual to conduct funeral services, but it was really the most gloomy year of his life. He had no "beloved physician" with whom he could consult in the hours of his loneliness!

There are times in the experience of pastors when there happen to be in their congregations representatives of several schools of medicine, or different representatives of the same school, and all devotedly attached to the pastor! Then it requires considerable tact on his part to prescribe for all the doctors in such a way as to give offence to none! A pastor is greatly to be pitied who happens to have in his church a physician of inferior attainments and low instincts, who is courting the custom of the congregation and unduly anxious to secure the patronage and influence of its pastor. The meanest use to which a Christian congregation can be put is to employ it as an advertising medium. No right-minded physician will ever find fault with a pastor or a church for exercising the right of private judgment in respect to the choice of medicine or the administrator thereof.

But if the parish preacher and the parish doctor can harmonize on the theory and practice of medicine as well as on the theory and practice of religion, there cannot be found elsewhere in the wide, wide world, two men who may be more useful to each other. In fact, to my mind, they appear to be necessary to each other's existence as well as usefulness. In the olden time the functions of the healer and the teacher were united in the same individual, and he figures on the pages of ecclesiastical history under the name of *Apostle*. Those were happy days for the afflicted public, who had need both of healing and teaching. Among the list of preachers in subsequent years, there have been none equal to Peter and Paul, and among all the disciples of Æsculapius there have been none who have done for the healing art what those celebrated worthies did. Then the two professions were happily combined. Now, unfortunately, they are separated, and so it comes to pass that we have in these latter days poorer preachers and poorer doctors than were known in New Testament times!

But ought not this fact in respect to their common origin draw the physician and preacher very closely together? We do not contend that these professions should form a partnership for the joint transaction of business, but that these two arms of the public service should so work as to aid each other in the alleviation of misery and multiplication of happiness. Let each man know his place and comprehend the nature of his mission. No doubt, it was very kind in the good old dominie, while circulating among his sick parishioners, to prescribe his favorite remedy—mustard-seed poultice--for all the ills his people were heir to. His judgment was so good in other matters that the people were in the habit of consulting him on all occasions, and he was free to recommend his poultice in all cases of sickness, even after the parish doctor, an elder in the church, had given his prescription. When the physician found that some of the people were silly enough to prefer the advice of the preacher to his own, he secretly concluded that the poultice remedy was becoming too monotonous in that region, but how to convince the people of their folly was another thing. Fortunately for the doctor, a crack in the church bell made it necessary for the dominie to call a parish meeting, at which he presided, to devise ways and means for restoring the tone of the bell. The hideous noise that came from the belfry whenever the sexton pulled the bell-rope distressed the ears of the people, and everybody was anxious to remedy the evil. One of the speakers recommended filing the fracture; another suggested an exchange of the old bell for a new one; and the third one proposed recasting the bell. The doctor now rose and astonished the people by reminding them of a sovereign remedy, so often prescribed by the moderator of the meeting in severe cases of sickness, viz.: the application of a mustard-seed poultice! He advised the congregation to try its efficacy on the cracked bell. In Latin, the prescription would probably be *Cataplasma usque ad nauseam*, but the congregation at once understood the English of it, and the dominie, after that day, ceased to prescribe!

We hear, occasionally, of a minister who attempts, in the sick room, to act independently of the physician. This is all wrong. The preacher has no right to interfere with the physician, or even to visit the patient, in case of severe illness, without the advice or concurrence of the physician. No matter what may be my interest in the

welfare of a member of my church or congregation. He may be the dearest friend I have on earth, and the physician of his choice may be an atheist, but he is responsible for the life that is imperiled, and I must act under his direction. It has been my duty, in some cases, to work with physicians whose religious opinions were repugnant to me, but I have always recognized the principle just set forth, and am happy, here and now, to say that in thus acknowledging this undoubted right of the physician over his patient, I have been met half way, and no physician has ever, to my knowledge, attempted to interfere with my duties as a Christian minister.

I regard it as a sacred duty on the part of the ministry, not only to show a friendly disposition to the medical profession, but to use our influence in maintaining its dignity. I have often admired the heroism, as well as self sacrifice, of the men who have not a single moment that they can call their own, and who are under so rigid a code of ethics that they cannot maintain their standing in the profession if they give the least countenance to quackery. As a class, the ministry is receiving large benefit from their brothers, the doctors. It is sad to see, occasionally, how a minister can cheapen himself by allowing the use of his name in the attempt to popularize a patent medicine. Some good and great men in the ministry take a different view of this subject, and declare their independence of what they are pleased to term the restraints imposed on them by the medical profession. But there are no restraints imposed. Each minister is free to act for himself in this matter. His reaping, however, will be according to his sowing. If he is willing to countenance practices that are condemned by the learned men of a profession that commands our respect, and that is closely allied to ours, and is in living sympathy with ours, he may expect but little help from physicians, as a class, in his mission as a minister of religion. It is highly important for both professions, that the members thereof should be in full accord on all practical questions. There may be a question as to whether the exigencies of the public service demand any quacks except those belonging to the order *Anseres*; but the world *has need* of all its physicians and all its preachers. The wants of the soul no less than the wants of the body require attention. There is no method that will remedy the crying evils of our social system and rescue the miserable outcasts from the slums of our cities, and help them to the "higher life," that ministers only to the body and neglects the soul.

Hospital Reports.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

CLINIC OF FESSENDEN NOTT OTIS, M.D., Clinical Professor of Venereal Diseases.

Syphilis.

Gentlemen:—I understand that we have today an initial lesion of syphilis, which is characteristic, presented to the clinic just as I was coming in. I have not had an opportunity to examine it, and I think this will be an advantage, inasmuch as we can pursue the examination together, and gain information in regard to the true character of the case, so far as we can go. So we will treat this case as though it had just come to our office, and try to find out what is the matter with him, and what is best to be done. We will ask when he first noticed this, taking it for granted that it is a venereal lesion, for men generally appreciate this fact when they come to see us. First, how long has it been since you had connection? "It has been eight weeks." Had you had connection before that time? "Yes, sir; it was six weeks ago, two weeks after the connection, that I noticed this on my penis." The patient says he had no reason to suppose he should have got this trouble from the party with whom he then had connection. It would seem there was an interval of two weeks between the connection and when he noticed this on the penis. It is sometimes very difficult to get accurate information with regard to time in these affections.

Lie down here, and let us make a careful examination into this matter. Gentlemen, there seems to be an epidemic of phimosis this year. This patient has phimosis. I think we must have had here and in the hospital at least twenty or thirty cases of it within the last month.

Now, we have here a characteristic condition, an apparent sore or lesion without any loss of tissue. On the contrary, there is an apparent increase, and there is nothing like a destructive action going on here, as far as I am able to judge. Here is a superficial sore about the size of a silver three-cent piece, and there is no accumulation of pus there. There is no evidence that suppuration is going on. There is a superficial erosion. That is what we call a chancrous erosion. This seems to be, then, one of the forms of initial lesion, and if it is so, as I put my finger upon it I shall find more or less induration, this depending upon causes which we shall consider very soon.

As I put my finger upon it I find that it is distinctly hard; it is not sensitive, it is not sore. Now, if any of you wish to do so, I would like to have you come down and gently touch the finger there, and you will realize what I have realized in touching it, that there is a body or material of cartilaginous hardness at that point, just beneath the superficial layer of integument.

Bear in mind that this is not a destructive action; it is not an ulceration, for reasons which I explained to you a week or two ago; the parts are quite supple in every way, except just there. Always when you put your finger on a sore like

this, which is open, be careful that you have not a little breach of tissue. If you get a little secretion from such a sore as that into a hang-nail, it may communicate to you syphilis. I had quite a fright the other day myself, in that way. I do not think I have been so much troubled in mind before as I was three or four days ago, when a doctor brought a patient to me who had a paraphimosis, the cause of which was evidently an initial lesion. In endeavoring to reduce it I inadvertently slipped my finger under the constricting band, and the sore folded over on to my finger; that is, the free surface, the secreting surface of the sore folded over on my finger, and on washing my finger a few moments afterwards I felt a little soreness on the side of it, and I found that I had a hang-nail that had been bathed in this secretion. Well, I felt very unpleasantly, indeed, and I got out my bottle of nitric acid as soon as possible, and was just about to make a very positive application, when I remembered that early in the morning I had pounded that finger, accidentally striking it with the hammer. I then took a magnifying glass and looked at it, and found the skin was unbroken; there was a little blood effused under the surface, and I was delighted to find the skin was not broken.

I speak of this to show you how easily one might take syphilis. Now it is quite possible that, had the skin been broken, and I cauterized it five or ten minutes afterwards, syphilis would still have been communicated. There might have been this little disease germ, of which we have spoken before, in such a relation to the open mouth of a minute lymphatic vessel that it should have been carried beyond the reach of possible cauterization. It is said in a general way, by some, that there is no such thing as stopping this; others say it may be destroyed. I have no doubt that in certain instances this syphilitic material may be destroyed after inoculation has taken place. In other instances I believe it cannot be destroyed. It depends upon the extent and the condition of the surface of inoculation and its relation to the lymphatic vessels. If there be a superficial lymphatic vessel ready to take this material up, it carries it out of the reach of cauterization at once. If, on the contrary, the material lies superficially, and has only been able to penetrate into a little lymphatic space, then you may destroy it. It is always worth trying, under every possible circumstance of inoculation. When it is sufficiently recent to give you any hope of success, you should not hesitate to cauterize; I should do it even days afterwards.

Now, here we have this erosion and this induration; the induration, as I was showing you last week, consisting, as shown by microscopical examination, of an accumulation of cells, cells just proliferated at this point, and for the reason which I explained to you, excited by the addition of an unusual stimulant to proliferation, this stimulation being a diseased germ, a degenerated white corpuscle. A microscopical examination shows that there is nothing but a packing of white blood corpuscles in such a way as to show that these cells have proliferated *in loco;* that they have come to this point as white blood corpuscles ordinarily come to a simple injury. But here there is a hardness, a hardness that is caused by the filling up of vessels and the walls of the vessels by these white corpuscles; whereas the walls of the vessels are not invaded in simple inflammation. That is why this is so much harder than in ordinary induration from inflammation.

Now, this accumulation is very positive, and it is in direct relation to what is called the period of incubation. Clinical observers have been at great loss to know why it is that in some cases there is an authentic incubation of only twenty-four or forty-eight hours. There are not many such cases, but I think we have a right to say there are some which have been reported under good authority. In others the period of incubation has been as long as seventy days and over. Now, of course, it has been said that this difference in the time of the incubation is due to the character of the virus. When we come to inoculate a number of persons with the same specimen of virus, we find the period to correspond pretty well in the several cases, the average length of time being about twenty-one days; but curiously enough the experiments were all made upon the integument, and the experimenters had not in view the ideas which I am now advancing. Now, what are we to do about this period of incubation, knowing that this material extends very readily (taking the view, as we have commenced to do, that this case is one of syphilis, and that this material is a lymphatic material, a disease of the germinal elements alone, and is confined to the germinal canals practically, and these canals are the lymphatics, or the tissue spaces and the canals of the lymphatic system)? Now, the accumulation of these cells at a local point would be, necessarily, at first in the lymphatic spaces, the tissue spaces which are found everywhere where we find this nutritive fluid. The nutritive fluid, the lymphatic fluid, the lymph, whatever you may choose to call it, bathes the parts at the point of abrasion where the germ or principle of syphilis touches. Then proliferation goes on, such as we have shown by real experiment takes place in the white blood corpuscles, and if that accumulation goes on, it goes on only in the line of the lymphatic vessels; first in the lymphatic spaces about the vessels at a given point, and in the lymphatic vessels themselves when it moves away from that point. You may say it is unreasonable that it should remain at that particular point, and not at once go throughout the system. But we know it does remain there, that there is no evidence that the system is infected until it has been through a certain curriculum. We have it at this point, and when it moves on, the first physical indication thereof is some places of accumulation of this same cell material in the lymphatic cord which runs along the top of the penis. We know from actual examination that it is a lymphatic vessel. We know, then, that the track of this accumulation is along the lymphatic vessels, and not through the blood vessels, which would carry it directly into the circulation. Then the next thing we find is, enlargement of the glands in the groin, and they are enlarged with this same material.

Now, why does this material accumulate in the

lymphatic vessels? This is a question easily answered with our present knowledge of the office of the lymphatic vessels. At one time their office was unknown. They were supposed to be absorbents. But they were found to constitute a channel in which certain fluids were ever moving from the superficial portions of the system toward the centre, and as they are found everywhere in suitable relation between the veins and arteries to answer as drainage vessels, as it were, and always contain germinal material, the idea was conceived that they answer the purpose of carrying back into the general circulation the nutritive material which is carried out in excess of the necessities of growth and repair in the tissues. Now, this seems a very common sense view of the matter. If you or I were going to build up such a body as this, we would naturally think of some means of carrying back the material which we did not want to use for building up tissue. This view of the use of the lymphatics has been accepted by one of the most recent authorities in physiology, namely, Foster, and a number of advanced and prominent men have accepted the view that the office of the lymphatics is that of a modeling system, a system which carries back into the general circulation this germinal, nutritive material which has been exuded into the tissues beyond the necessities of growth and repair.

We may now consider with propriety what are the conditions, and what the time required, for this material to get back into the general circulation, and I will show you positively that we can account for the reasons why this disease germ of which we have been speaking stops here and there on its way into the general circulation. I am going to show you how the different periods of so called incubation are established.

In the first place, we have the primary incubation, or the period after inoculation, of three or four weeks, before the induration makes its appearance. Now, we will suppose, if you please, that the disease material finds some difficulty in gaining access to the lymphatic vessels, for the lymphatic vessels are not everywhere. There are spaces, but vessels running to lymphatic glands do not exist everywhere. Now, this disease germ which has entered a lymphatic space becomes incorporated with a white blood corpuscle, in the manner which I described last week, and they increase by the increased activity imparted by the presence of this stimulating material. The process of proliferation at that point is increased. Another thing to be taken into account in explaining the accumulation of these cells, is, that the proliferation is going on where the circulation is retarded, or where it is slow. This proliferation goes on until it extends to a lymphatic vessel, and we have such an accumulation of material here as gives a cartilaginous feel. After it has extended to the lymphatic vessels, we put our hand in the groin and find the lymphatic glands there enlarged, as I do in this case. The same process which existed at the point of inoculation has been transferred to the lymphatic glands. This is always the case. It does not find its way into the system in any other way than through the lymphatics.

You ask why the blood is not affected? If we stick to our original text, we will see that we have a material which cannot by any possibility combine with the blood. It is unformed germinal material, and can only combine with material of its own kind. It cannot combine with red blood corpuscles because these are a higher form, they are elevated above the white. Foster accepts this as true. It cannot, I say, blend with a red blood corpuscle. It must, by its amœboid movement, make its way into a cell, and then, as does a white blood corpuscle, find its way among the red corpuscles. This is the reason why it does not go through the system as the poison of other contagious material. It goes along in this sort of way, coming in contact with germinal material, and consequently keeping to the lymphatic spaces, in close contact with the lymphatics, finally filtering through and working its way to the glands of the groin, and there it is held.

We have seen how it may be held for days and weeks, constituting the first period of incubation, before it gets into the lymphatic vessels. Now, in order to show you that this is more likely to be the case than any other, we have circumstantial evidence of the most positive character. A very distinguished surgeon in the Confederacy, a number of years ago was making an amputation on a syphilitic subject, and injured his finger with a spicula of bone. That night he found an enlargement of the glands, with a little engorgement which produced a red line, and discomfort, and that night, or the next day, he found the glands in the axilla enlarged, and within six weeks from that time he had a general roseola. The wound of the finger healed without the slightest evidence of any hardness, or anything whatever to show its presence. Yet, he had not only the secondary syphilis, but this was followed by tertiary lesions. The doctor gave me the history of his case himself, after I had made an argument in favor of this view of the period of incubation before one of the societies. He came forward, after the lecture was over, and told me his case in support of my view, and I consider it one of the strongest proofs I have.

Another proof is, as we shall see constantly at this clinic, that in all cases where there is a short period of incubation, as of three, four, or five days, the lesion is near the frænum. Now, men who have made the lymphatic system a study, tell us that the lymphatics come more closely to the superficies of the body at the frænum than at any other point; in fact, that they lie there just underneath the epithelium. This, I say, is a reason why in one case we have a short period of incubation, while in another a long period. The period of incubation, when inoculation has taken place on the body of the penis, is also short, for here, too, the lymphatics come very close to the surface. So that we have a reason for this difference in the length of the period of incubation which is verified by microscopical and clinical observation, and we have an explanation of the way in which the lesion is formed, and the course the virus takes to get into the general system. After the glands in the groin have been reached, if the lesion first be on the penis, or the glands in the neighborhood of the initial lesion,

wherever this may have been, there seems to be an arrest of proceedings. We hear nothing about syphilis, or any sensation or sore of any kind, on the part of the patient, under thirty or forty days. That is the second period of incubation, so-called. Now, if the system, as is claimed by some, be pervaded throughout with this poison, why this stay of proceedings? There must be some reason for it. The time has passed when we could accept it as a mysterious matter and let it alone. We find that there is a convolution of vessels in the interior of this gland, through which, as the germ enters the gland, it requires a long time to pass. There is here a gummy fluid which holds this disease material, obstructs its progress, but not entirely, for it has its amœboid movement, and finally passes through, requiring, however, about forty days. Then we find an eruption coming out. We know that this does not amount to much. It comes out when a man is feeling perfectly well, as I showed you last week. It is only a roseola, which never becomes anything else; never becomes a papule or an ulceration. It comes and goes as a roseola. It fades out and leaves a copperish tint, and I suppose that everybody, almost from the beginning of the history of syphilis, has recognized these copper-colored spots as due to syphilis. Now, we know, later, that this is not a fact. That is, microscopic observation tells us that it is hæmatoidin that gives us the copperish color. It is crystallized blood, hæmaglobine which we find under the skin. And in this way we may account for all sorts of staining. Blood has been effused.

Now, what causes blood to be effused where no injury occurs? Of course it must be by some loosening of the vessels. How are blood vessels loosened? By their nervous influence being loosened; by a sort of pyresis of the nerves connected with the vessels, which allows the vessels to relax and the blood to exude. We understand that all cases of roseola are caused by pyresis of the blood vessels, which lets the blood out for a brief period, and then, in most instances, it passes away; is transitory. And that is one of the differences between the irritation that produces a gastric roseola and that which produces a syphilitic roseola. In the first case it is more temporary, as the gastric disturbance passes off; in the latter case it is more permanent, and why? Because it is connected, as you know, with the sympathetic system. I think it may be shown through circumstantial evidence, independent of any other; for when the vessels of the lymphatic system have permitted the passage of these germs, or this material, into the receptaculum chyli, they go with a rush into the subclavian vein and are turned suddenly into the general circulation. Now, would you not think that enough to affect the sympathetic system, when a word will do so in the case of a sensitive woman, calling forth a blush? Many of you know of cases here where a sense of shame or mortification has brought out a roseola upon a sensitive woman, which remained for hours. An oyster taken by some very delicately organized persons will bring out a roseola in a very few minutes. If a word will do it, if a thought will do it, why refuse to believe that a myriad of these active bioplasts, diseased and active germ elements, poured suddenly into the circulation, should produce an equal effect? We have to suppose this, because we cannot follow that thought with our microscope yet. But circumstantial evidence is in our favor, as now, for the first time, this disease element has gotten into the blood, and this is the first positive evidence of it. It now has access everywhere, as a matter of course, because where the blood current goes it goes. And now the superficial capillaries begin to get full of these cells. Why? Because they go just as far as they can go, and that is into the papillæ cutis. They cannot go further. In this diagram you will notice blood capillaries coming up into the papillæ cutis, and following right up underneath is a lymphatic capillary, intercallated between the veins and arteries, and in the papillæ cutis is ever present this lymphatic vessel, the office of which is to carry back material exuded in excess of the needs of growth and nutrition. Now we have this disease germ, or the white blood corpuscle that has received this influence, passing with the rest of the elements of the blood until it gets to that point where a certain amount of it is exuded for the purpose of repair and growth, and it is at a point where the circulation is slowest, so that we find it in the most favorable condition for proliferation. We have this material in exactly the locality where we would put it if we wanted it to proliferate. We would naturally suppose that here we would get an accumulation of cells.

Now, recently the microscope has been brought to bear upon a great many things, and to me not the least interesting are the papules of syphilis. They have been found to consist of cells exactly like the cells we find in the glands, like the cells we find in the induration of the initial lesion. So far we have a right, then, to suppose they are the same. A distinguished observer, who is authority now on microscopical examination, says of these syphilitic papules, in opposition to views formerly entertained regarding them—namely, that they were enlargments of hair follicles, of sebaceous glands, of one thing and another—that they are always located in the papillæ cutis, and if they are found anywhere else it is only because this accumulation has enclosed a sebaceous follicle, or a hair bulb. But they always begin in the papillæ cutis

Now we find the eruption following immediately the access of this material into the general circulation, an eruption of peculiar character. It is what is called the papillary eruption of syphilis, which consists of elevations of the skin, caused by the accumulation of this germinal material, which is confined to the papillæ cutis.

Here is another patient who has the eruption on the skin, and if we inquire into his history I doubt not we shall find it coincides with the theory we have been advancing. How long has it been since you had a sore on your penis? "Three months." How long have you had this eruption? "Two weeks." From what we have said, gentlemen, you know why he did not have this eruption when he first had the sore.

If, as some authors claim, the poison pervade the system from the moment inoculation takes place, why did he not have the eruption from the first? According to that view, the eruption should certainly have been out within a week, or at most a fortnight from the time of inoculation. Instead of that it did not come out for nearly three months. Why did it not come out before? Because of the course it must take, which we have just been considering. But when we do find it, we know it is nothing more nor less than an accumulation of this germinal material, which, under the microscope, cannot be shown to be different from healthy germinal material. This eruption has a peculiar color, a copper tinge, and because of its being of a copper color it is called by some syphilis; but it is not because of the coppery color that it should be called syphilis. It has a copper color because blood has been exuded. The copper-colored eruption would mean nothing in the way of syphilis if there were not a syphilitic history back of it. A simple eruption upon the skin does not constitute syphilis, for an eruption may be due to various causes, but you should take a step back in the history, and learn about the initial lesions, enlarged glands, etc.

Here we find spots which show that there has been an eruption previous to this, a roseolar eruption, and that never develops into this papular eruption, for reasons which you can understand. The cases are different. But now we have a papular eruption of syphilis, characterized by certain peculiarities of form and locality, but not essentially so, because in one case the papules are located where they are as big as a sixpence, while in another they may be distributed all over the body, no larger in size than a hemp seed. You have in your books on syphilis half-a-dozen varieties of the papular eruption of syphilis. Then you have the pustular eruption, and its varieties. Now, these divisions are unnecessary to an understanding of this subject. It is well enough to know about them if you intend to write a book upon the subject, or if you wish to make very nice distinctions, but what you want above everything else is practical knowledge, which shall enable you to understand what it is that is producing this condition, and what you shall do for it. Instead of making out all these varieties of papular eruption, you should go back to the commencement of the history of the case, and if you get a straight history, a history of initial lesion, followed by enlargement of the glands in the groin, then of the glands at a distance, then by an eruption, you have, no matter how the eruption looks, a case of syphilis, and by treating it as such you will be on the right way.

Now, here is another patient, and he has a pustular eruption, with scabs at different points. In the other case there was a papular syphilide; in this, a pustular syphilide. The difference being, that one has suppurated and the other has not. They are both caused by an accumulation of cell material. Why one should suppurate and the other not, I cannot tell. It depends upon some dyscrasia, I know not what. An eminent authority in skin diseases says these papules are formed of cells, which under certain circumstances are heaped together and form a detritus, and make pus. Now, shall we make another variety of skin diseases because this patient has some condition of things which induces suppuration? The papular eruption on this other patient may change into a pustular eruption within a week, or he may have some papules and some pustules, so that we will have to make another variety, a papulo-pustular variety. A great deal of time is spent unnecessarily in making out these varieties of the eruption. The one important thing for you to recognize is the cause of the eruption; whether it be due to syphilis. You will know when you see the patient, if he have a pustular eruption, whether he will require different treatment from what he would were the eruption of a different variety.

Let me repeat that the syphilitic eruption is not caused by any destructive principle in this germ material, these blood bioplasts. It is caused by their indolence, their helplessness, and tendency to heap together so as to interfere with the processes of nutrition. In some cases this is carried to such a degree that suppuration occurs.

Now, what we want is to get rid of them. How can we do it? By the administration of mercury. And we should not content ourselves with saying simply that mercury is an antidote for syphilis. We should understand its action. We have in mercury something which produces in healthy tissue fatty degeneration, and when we have an accumulation of material in the system, and wish to get rid of it, we use that agent which, above all others, has the power to produce fatty degeneration, that is mercury. That mercury has this power we know from clinical experience. But we give it now, not with the idea that it is an antidote for syphilis, but with the idea that we have this accumulation of material which we wish to get rid of. Ricord said, a few years ago, before one of the societies in London, when called upon to speak upon this subject, that he believes syphilis can be cured, and that it can be cured by giving small doses of mercury for a long period of time. If a patient who comes to me says he cannot spend the time to be treated a year, I tell him to go away; I cannot treat him.

Then, gentlemen, you see that our course of reasoning from circumstantial evidence has brought us to this point in the treatment, that this accumulation of cell material is to be gotten rid of by fatty degeneration, that mercury is the remedy which best fulfills this indication, that it should be given in small doses, just sufficiently large to produce this effect, and not large enough to disturb the healthy structures of the human organism. Clinical experience as well as reason verifies the propriety of this mode of treatment.

More About Trichinosis.

An inspector of hams in Hamburg celebrated last month his discovery of trichinæ, in a round thousand of American hams since January, 1879. In Berlin, in September, out of 11,116 hogs killed there were only seventeen found trichinous. No wonder, from such facts as these, which we find mentioned in the same Berlin exchange, the Germans are growing fearful of our products.

Medical Societies.

THE TRI-STATES MEDICAL SOCIETY.

Sixth Annual Meeting, held in Louisville, Ky., Nov. 9th, 10th 11th, and 12th, 1880.

Reported for the Medical and Surgical Reporter, by A. H. Kelch, M.D.

The Tri-States Medical Association, composed of representatives from the States of Indiana, Illinois and Kentucky, opened its Sixth Annual Session in this city, on Tuesday, Nov. 9th, with about fifty visitors present. The President, Dr. H. B. Buck, of Springfield, Ill., called the Convention to order at 10 A. M., and the exercises then began, after an invocation by the Rev. Jas. P. Boyce.

Mr. Laf. Joseph, chairman of the Common Council, was first introduced, and in an address of welcome in behalf of the city, briefly spoke of the fitness of holding the convention in this city, where, no doubt, many of its members graduated; addressed a tribute to the philanthropy which is the foundation principle of the medical profession, and likewise extolled it as being the source from whence literature has derived some of its brightest stars, and from which has been born unto science some of its greatest philosophers. He spoke of the great opportunities which the duties and responsibilities of medical men gave them to become acquainted with the weakness of poor human nature, and praised the profession in which so few use that knowledge for other than philanthropic and honest purposes, closing with the following strain: "Whether you come from where the clear limpid Sangamon washes the borders of the flowing prairies, or from the beautiful banks of the broad Kankakee, or the swift flowing Wabash; whether from the cliffs that so majestically overlook the rushing Kentucky, or from the gently undulating slopes which border the Cumberland and the Tennessee; whether you come to renew friendships, formed years ago, or to form new ties; whether you come to seek rest from a busy season, or gain new thoughts at the feet of the great men assembled here; whether you come to again feel the genial warmth of the encircling arms of your *Alma Mater*, or to furnish rich drops of thought from the overflowing fountains of your own fertile brains, you are welcome to our beautiful city, welcome to the warm hearts of her hospitable citizens; and when your labors here shall have been completed, we wish you all a happy return to your homes and your duties, refreshed by your season of good fellowship, and better fitted for your struggles against fell disease. In the name of the city of Louisville, I bid you welcome and good cheer."

Immediately after Mr. Joseph had spoken Gov. Blackburn, who is also a member of the medical profession, was introduced and delivered an address of welcome in behalf of the State, in which he said, "more temporal good has resulted to the world from the discoveries made by men in your profession in the last century than from those of all other professions combined." Anticipating the pleasures of the meeting likely to ensue at the proper time, he "hoped that the utmost good humor would prevail in the discussion and honest differences which would probably arise between the members, on questions not definitely settled; that harmony would be characteristic of the meeting, and that deference and courtesy would be shown by each to another."

Dr. E. R. Palmer, of this city, was then introduced, to speak in behalf of the profession of the city.

Dr. Palmer referred, in his characteristic way, to the meeting of the American Medical Association, at Cincinnati, in 1866, when the East had determined to attempt the renewal of that national professional friendliness that in antebellum days had had its embodiment in the American Medical Association. The appointed day came, and with it, from every quarter, members of the delegation, which was small, but representative. Dr. Davis, of Chicago, the father of the Association, spoke hopefully, yet doubtingly, of the future, and for the moment it seemed a question whether good would come of the meeting. At this juncture a Kentuckian took the stand. He spoke regretfully, yet manfully, of the past, and as his mind filled with the recollection that in all the bitterness and bloodshed of the war the bond of professional brotherhood had ever proven too subtile for the sword, too solid for the bullet, he warmed to his theme, and in the name of every doctor in the South extended the hand of fellowship to the profession of the North. . . . . We meet to-day under similar circumstances to those which surrounded our brethren at Cincinnati. A battle has just been lost and won, fought, as of old, on the miserable issue of sectionalism. The smoke of the conflict clears away and again the sun shines on American doctors in council. The Northern doctor has crossed the Ohio, assured of an honest welcome by the profession of Kentucky. The press tells us that with the conflict just ended old issues must pass away and new problems come to the front, before which a "solid South" and a "solid North" must break in pieces. God grant that they may break, if they break but to blend, so breaking and so blending that abstract issues shall succeed to social issues and polemical tilts supplant forever sectional broils. All of the strongest ties known to man bind together the States represented here to-day, and I feel assured that if the voice of the people, which is the voice of God, be half heard, that bond can never more be severed. . . . . You have come, gentlemen, to the metropolis of a people known the world over for possessing and producing the greatest comforts and delights of life—Kentucky tobacco, Kentucky horses, Kentucky whisky, and last, but not least, Kentucky women. Go where you will, from Orient to Occident, the world teems with their praises. You are to meet and mingle with a profession rotund and complacent under their benign influences. The best wish I can bestow upon you is that you may catch the infection while you stay, and bear its solacing power even unto the ends of your lives. Our latch-strings hang on the outside of the door, and our wives and daughters stand ready to fill the pipe and draw the cork if you will but enter. Again I bid you welcome to our city and our homes."

These addresses were briefly responded to by Dr. J. W. F. Gerrish, of Seymour, Ind. The reports of the various committees and officers occupied the remainder of the forenoon session.

AFTERNOON SESSION.

At 2 P.M. the Association again convened and the regular presentation of papers began. The first to respond to the call was Dr. J. V. Black, of Jacksonville, Ill., who read a paper on the "Hysto-Pathology of Scarlet Fever." Dr. Black accepts the common definition of the disease, holding it to be a contagious epidemic disease, propagated by a peculiar and specific poison, the effects of which are manifested upon the constitution, and then locates the characteristic lesions of it in the squamous epithelium of the skin and the columnar epithelium of the alimentary tract, and those tissues derived from the same thelia out of which these are evolved. The evolutions of the external blastodermic, endodermic and internal blastodermic membranes to form the various parts of the system were then considered, and the relations between the parts traced, in order to maintain the proposition concerning the seat of the characteristic lesions. The rash was considered a prime and typical phenomenon, and it was noted to consist in an inflammation of tissues that have no vascular system, and generally no nerves, and hence but two of the symptoms of inflammation can be manifested. Acknowledging the fact that redness is one of the distinctive characters of the rash, he denies this redness to belong to the tissue itself, but attributes it to the expansion of the capillaries between the tissues involved in the inflammation; that while there was hyperæmia the capillaries were not further involved in the changes. Dr. Black finds in the discovery by Fenwick that the basement membrane of the sweat glands is thickened and sometimes lost, an explanation of the bleeding surfaces sometimes seen. From the sweat glands, he says, the inflammation quickly extends to the epithelium and soon involves it entirely. From this, however, it is not to be inferred that scarlet fever attacks the sweat glands especially. This is not the case. It is not the sweat glands, as glands, that is the point of attack, but their epithelium. As evidence of this he adduces the example of burns which have destroyed large portions of the skin, in which the glands are not renewed; the epithelial covering here is attacked by the rash as quickly as any other portion of the skin.

Speaking of the connection between the fever and the rash, he says that while the fever is known to precede the appearance of the rash for a few hours, its inflammatory character suggests the idea that they begin together, and that the fever is largely a consequence of the rash, although apparently preceding it. To prove the inflammatory character of the rash it is noted that the epithelium is softened and more easily removed, and that these changes are the result of inflammation and showing more than simple hyperæmia.

On the subject of the desquamation the author of the paper remarks that there is such a close agreement that it might seem superfluous to add anything. He holds, however, that the desquamation extends to the epithelium of the alimentary tract and the tissues differentiated from it, and that this extension of the desquamation accounts for many of the results which are known to follow an attack. He adduces in favor of the theory that Dr. Hall, of London, found intestinal lesions in scarlet fever, sufficient to lead him to consider that a close relation exists between it and enteric fever.

In connection with the involvement of the kidneys the author says there is an error in the minds of many with reference to its nature; it is regarded as a complication, while, in fact, it constitutes one of the intrinsic characters of the disease. The fact that it is a grave feature in some cases does not make it any the less a factor of the disease, and we have reason to believe that it figures more largely in the beginning of the disease than is generally supposed; the affection here being at this time overshadowed by the more prominent and apparent conditions. Very early in the disease the cortical substance is particularly the seat of morbid changes. There occurs here the analogue of what occurs in the sweat glands of the skin. The blocking of the tubules gives rise to inflammation by the retention of irritant material, and when the stage of desquamation comes on the tubules are unable to force themselves from the accumulated epithelial casts; a mechanical effect ensues which is superimposed upon that already existing. The structures derived from the endothelium present, as might naturally be supposed, a healthy appearance. The fact that these are widely separated, both in structure and function, from those of the epithelial basis would indicate their exemption. Still, the rapidity with which the blood courses through the circulatory system favors the idea that they are more or less involved.

Of the respiratory system we have more definite knowledge. Almost every author who has had anything to say upon this subject proclaims that when the inflammation extends to the air passages it should be considered diphtheria or croup. We have the most satisfactory evidence that in most cases the respiratory epithelium is exempt except where it comes in contact with the squamous epithelium. At these points there is more or less change in the type of each of the thelia, constituting an intermediate type. Notwithstanding this fact, however, the scarlatinous inflammation does not cross the line so readily as might be supposed. If the inflammation be severe, however, as sometimes happens, and it pass to the respiratory epithelium, then the changes which take place are, no doubt, of a different character from those which take place in the squamous variety; different in that the tendency is to rapid destruction of large portions of the covering. The large number of cases in which the auditory power is destroyed makes the consideration of the extension to the middle ear of importance. This extension undoubtedly occurs through the medium of the Eustachian tube, and this readily occurs whenever the line is once crossed and the inflammatory process has begun in the respiratory epithelium. The crossing of the line at the glottis is a much more rare occurrence, but when it does occur it is characterized by the same destructive processes which

occur in the auditory canal and nasal passages. The involvement of the tonsils and post-lingual glands is a point of the utmost importance; they seem to form a common point for the inflammation to take its origin. This seems to be the point from which the involvement of the respiratory epithelium occurs. The comparative freedom of the lymphatic glands, together with the lobular glands, the clinical history of the disease seems to prove beyond question. This is somewhat surprising when we consider their derivation from the ciliated epithelium. So far as we know the lobular glands are not affected, while, on the other hand, the tubal glands are involved as uniformly as the thelia from which they are derived, and they very often appear to suffer even more severely.

In conclusion, Dr. Black states that the departure of the disease from the tissue of its election is found to be to the respiratory epithelium in the larynx, pharynx, and to the lymphatics in the connective tissue of the tonsils and post-lingual glands. In the case of a departure from the tissue of its election, it is accompanied by a radical change in the type of the inflammatory process.

The dangers of the disease are: first, life is threatened in the febrile stage from the effects of the greatly-increased temperature upon the nervous centres; second, life is threatened by the involvement of the kidneys, and dropsical effusions into the pericardium and other cavities; third, the involvement of the lymphatics of the throat and neck threaten life by the formation of abscesses, and consequent pyæmia, and by extension; fourth, by the involvement of the respiratory epithelium with its underlying tissue, troublesome chronic catarrh is likely to result; fifth, the involvement of the Eustachian tubes and middle ear threaten either a destruction of the organ of hearing, or second, life, by the escape of pus into the cranial cavity.

The next paper presented was by Dr. J. B. Richardson, of Louisville, on tubercular cerebral meningitis, and under the call for volunteer papers, Dr. Wm. H. Wathen, of Louisville, read on the subject of lacerations of the cervix uteri.

At 7.30 p.m., the Association re-assembled to listen to the address of the President, H. B. Buck, M.D., of Springfield, Illinois. It was then announced that at the beginning of the morning session the Society would be favored by an address from S. W. Gross, M.D., of Philadelphia. Accordingly, when the convention was re-opened, Dr. Gross read a paper on malignant tumors of the mammary gland. Dr. Gross's paper was founded on his observations in his work on this subject, and was warmly received. On the practice of medicine, Dr. B. M. Griffith, of Springfield, Ill., next read. In order to collect data for the foundation of this paper, Dr. Griffith addressed a number of questions to physicians throughout Indiana, Illinois and Kentucky, such as: "What are the prevailing diseases in your locality, and how treated;" "Give points in diagnosis, new or original;" "Give new or unusual therapeutics in your practice;" also, "application of old or new remedies to greater advantage than formerly."

To these questions very pointed and definite answers had been received, the first usually absorbing all attention and answered in this definite manner. "The prevailing diseases are malarial, typhoid, inflammatory, and rheumatic; treated in the usual way." With this startling array of facts laid before him, Dr. Griffith noticed the views concerning disease that have held the sway in medical minds within the last decade. The favored of these views have been "exposure to cold," "insufficient clothing and food," "bad surroundings in general, and depressing causes of whatever nature." To a thinking mind, he adds, these causes are as unsatisfactory as a Hades of fire and brimstone to an Ingersoll. Excessive heat caused yellow fever, malarial fever, cholera infantum, etc. Excessive cold, inflammation of the respiratory apparatus, and serous tissues, and in the event of the absence of either of these causes, the changes had been rung on "arrested secretion." At the present time the weakness is in favor of innutrition. The division of pneumonia into catarrhal, croupous and hypostatic, was offered as a striking illustration of the advance made in nosology. Instrumental aids to diagnosis received attention.

Of the epidemic diseases that had prevailed none had been attended by a great increase in the mortality. In addition to the remedies usually employed in diphtheria, universal commendation of the antiseptic spray of carbolic acid and iodine in the local treatment had been heard. The same might be said of salicylic acid. The tried and the true remained the standard remedy throughout Illinois, for malarial disorders, though several cases had been successfully treated by inhalations of nitrite of amyl. Quinine hypodermically and without reference to fever or the condition of the bowels is being more extensively employed. A peach kernel bruised and given once every two or three hours had been signally successful in cases of chronic intermittents, and has also been found to be an efficient anti-emetic, its virtue probably residing in the hydrocyanic acid it contains.

Typhoid fever has prevailed, though not extensively, in all localities; whether contagious or generated *de novo*, it is *sui generis*. Quinine, the *sine qua non* in intermittent, is not exhibited except as a general tonic. Salicylic acid alone during the pyrexia, or in combination with belladonna, has been given with satisfactory results. The value of quinine in rheumatism and neuralgia is not fully appreciated.

Inflation and forced respiration are engaging the attention of the profession, and are meeting with success in chronic bronchitis and many other forms of pulmonary disease.

In reference to anæsthetics, the A.C.C. mixture in parturition and minor surgical operations was highly lauded.

Among the new remedies noticed those which have stood the crucial test of experience, are: ingluvin in the vomiting of pregnancy, extract of broom tops in the general dropsy from renal disease, and extract of red clover in preventing the development of secondary cancer.

The forenoon session closed with the reading of a paper on State Medicine, by Dr. Horace Wardner, of Anna, Ill.

(To be Continued.)

Editorial Department.

Periscope.

The Diagnosis of Rötheln.

Dr. James Robinson writes, in the *Lancet*, Oct. 16:—

Rötheln in its general characters presents various degrees in severity, just as do the allied diseases, scarlatina and measles:—

The simple form, in which the rash is well out, the sore throat slight, and the irritation of the bronchial mucous membrane moderate, with slight coryza and sneezing.

The severe form, in which the catarrhal symptoms are still very perceptible, but in which the brunt of the attack is borne by the throat.

There is also an intermediate variety, in which the general symptoms are severe and the influence of the poison is exerted equally upon the skin and mucous membranes.

The period of incubation seems to vary, generally being about six or seven days, at the end of which time symptoms of a slight cold make their appearance, speedily followed by a considerable and sudden rise in temperature, hoarse cough, and sore throat, accompanied by watering of the eyes, headache in adults, or a convulsion in children, sickness, and sometimes severe vomiting. On the second day of the fever the rash makes its appearance, usually first on the neck and chest, afterwards the trunk, face and extremities, in patches of varying size, which soon coalesce and form larger ones less crescentic in form and of a brighter color than in measles, attended by considerable itching and perceptibly raised above the level of the surrounding skin. It begins to fade on the following day, its complete subsidence being rarely prolonged beyond the third or fourth day, with slight desquamation of the cuticle, which in mild cases is almost imperceptible. The temperature, at first very high, often reaching 103° or 104°, falls with the subsidence of the rash, except the throat symptoms (always present) predominate, when it continues high until the termination. The pulse may be 120 or 130, or even more frequent, declining suddenly with the temperature. There is sneezing, and the eyes are suffused, but severe coryza is absent. Hoarse and troublesome cough, with sometimes severe bronchial catarrh, are also present.

In mild forms of the disease it most resembles an attack of measles with sore throat of varying intensity and swelling of the cervical glands. In the more severe types, it is most like scarlatina anginosa, with the rash and catarrhal symptoms of measles. I have not observed any suppuration of the cervical glands, albuminuria, or dropsy, even when the scarlatinal symptoms seem to be in the ascendant. The most frequent complications seem to be bronchitis and pneumonia. The mortality in my experience is low, and death occurs most frequently from chest complications. The essential points in the differential diagnosis of rötheln from measles are in the presence of the throat and gland symptoms, and the early period at which the rash makes its appearance; and from scarlatina, in the presence of the catarrhal symptoms, the character of the rash, the manner in which desquamation of the cuticle takes place, and the complete absence of the sequelæ common in scarlatina. The strongest evidence of its non-identity with these two diseases, separate or combined, is that it is non-protective against an attack of either, and *vice versâ*; and this fact alone goes far toward establishing its claim to be classed as a specific and separate disease, possessing well-marked and distinctive diagnostic features from any other of the exanthema.

The Influence of Music on the Circulation of the Blood.

Dogiel, quoted in the *Lancet*, observes that music excites, both in men and in animals, pleasant and unpleasant sensations, the effects varying with the individual and with the quality of the music. The Greeks long ago discriminated several forms of music according to their influence on the body, under the names of Pharygian, Lydian, Æolic, and Doric styles. Aristotle saw in music one of the most important means of education, and Plato considered it to be necessary that music should be studied from the thirteenth to the sixteenth year. Pythagoras held that music might be made serviceable in the treatment of various diseases. In short, the ancients were well aware that the human body is powerfully affected by music. Dogiel made a series of experiments both on men and animals, the results of which he sums up in the following propositions. (1) Music exhibits an influence on the circulation of the blood, both in animals and in man. (2) The blood-pressure sometimes rises, sometimes falls. These variations in the blood-pressure depend essentially on the influence of the excitation of the auditory nerve on the medulla oblongata, which is apparently in direct continuation with the auditory nerve. (3) The action of musical tones and pipes on animals and man expresses itself for the most part by increased frequency of the cardiac contractions, and hence it follows that the automatic centres of the heart act with greater energy. (4) The variations in the circulation consequent on musical sounds coincide with changes in the respiration, though they may also be observed quite independently of the respiration. (5) Strychnia increases the effect produced by stimulation of the auditory nerves on the circulation, while curara diminishes it. (6) Chloral hydrate, as well as ethyl, alcohol and morphia (in a certain stage of the narcosis produced by them), diminish the action of the auditory excitation on the circulation. (7) The variations in the blood-pressure are dependent on the pitch and loudness of the sound, and on the tone color. (8) In these variations of the blood-pressure the idiosyncrasies of the indi-

vidual, whether man or animal, are plainly apparent, and even the nationality, in the case of man, has some effect.

Reviews and Book Notices

NOTES ON CURRENT MEDICAL LITERATURE.

——"How a Person Threatened or Afflicted with Bright's Disease Ought to Live" is the subject of a neat little monograph of 87 pages, by Joseph F. Edwards, M.D. It is divided into four parts, Part I containing general remarks on Bright's Disease, Part II treating of the functions of the kidneys and their derangements, Part III giving the pathology of Bright's Disease, and Part IV, Rules of Life. It is published by Presley Blakiston, 1012 Walnut street, Philadelphia. Price 75 cents.

——We have just received, in a volume of 97 pages, 8vo, "The Acts of the Legislature of Louisiana, Establishing and Regulating Quarantine for the Protection of the State; Organizing and Defining the Powers of the Board of Health, and Regulating the Practice of Medicine, Midwifery, Dentistry and Pharmacy, and also Rules and Regulations of the Board of Health of the State of Louisiana, and Health Ordinances of the City of New Orleans," by Joseph Jones, M.D., President of the Board of Health of the State of Louisiana.

BOOK NOTICES.

Diseases of the Throat and Nose, including the Pharynx, Larynx, Trachea, Œsophagus, Nasal Cavities, and Neck. By Morell Mackenzie, M.D., Senior Physician to the Hospital for Diseases of the Throat and Chest, Lecturer on Diseases of the Throat at the London Hospital Medical College, etc. Vol. I. Diseases of the Pharynx, Larynx, and Trachea. Philadelphia, Presley Blakiston, 1012 Walnut street, 1880. Cloth. 8vo, pp. 570. Price $4.00.

This work is divided into three sections, treating of diseases of the pharynx, larynx, and trachea, respectively. It is, the author informs us in his preface, based partly on the courses of lectures which he has annually delivered at the London Hospital Medical College during the last twelve years, and partly on his essay on "Diseases of the Larynx," to which the Jacksonian prize was awarded by the Royal College of Surgeons of England. The author treats his subject in a thorough and systematic manner, and his large experience and intimate acquaintance with the results of the labors of others, are sufficient guarantee that the book is fully up with the times. With regard to the use of mercury in syphilis, he entertains the views of Prof. Sigmund, of Vienna, and never employs it as an internal remedy, except in extreme cases, where local measures have failed. The work is well illustrated, and has an appendix containing special formulæ for topical remedies, such as steam and spray inhalations, gargles, lozenges, pigments, insufflations, and nutritive enemata. The book is gotten up in the usual elegant style of the publishers.

Handbook of Chemical Physiology and Pathology, with Lectures upon Normal and Abnormal Urine. By Victor C. Vaughan, M.D., PH.D., Lecturer on Medical Chemistry in the University of Michigan, etc., etc. Third edition, revised and enlarged. Ann Arbor Printing and Publishing Co. 1880. Cloth, 8vo, pp. 351.

The nature of this work is fully explained by its title, and to those interested in the study of the subject whereof it treats, it will prove a valuable aid. The first seventy pages are devoted to the subject of digestion, including the analysis of the saliva, the gastric juice, the bile, the pancreatic and intestinal juices and the fæces. The blood, lymph and chyle are next taken up for consideration, and then the spermatic fluid and milk. The solids of he body, epithelium, hair, elastic and connective tissue, cartilage, bone, muscle and nerve tissue are next examined; the remainder, or nearly one-half of the book, being devoted to the urine, its normal and abnormal constituents, and the detection of medicinal substances therein. Twenty-eight plates with forty-eight illustrations are appended. The student of medicine and the scientific practitioner will undoubtedly find this work useful.

The Physician's Visiting List for 1881. Philadelphia, Lindsay & Blakiston. Price $1.25.

This well-known and admirably arranged visiting list has now reached the thirtieth year of its publication. It is arranged for fifty patients per week, and contains, in addition to blank pages for monthly memoranda, addresses of patients and others, nurses and their references, accounts asked for, memoranda of wants, obstetric engagements, vaccination engagements, records of births and deaths, etc., etc., an almanac, table of signs, Marshall Hall's ready method in asphyxia, poisons and antidotes, the metric or French decimal system of weights and measures, posological table, and table for calculating the period of gestation.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA

WHAT DETERMINES THE SEX OF CHILDREN?

So many interests centre in the discovery of the laws which determine the sex of children, that no apology is needed for bringing the more recent views on the subject to the attention of readers.

The latest studies exclude, or nearly exclude, any supposed information which could be derived from the study of sexual development in plants or the lower animals. In the former, it is principally a matter of nutrition, and to some extent so in the latter; while in man this is certainly not the case.

The first question is, *When* is sex determined? Is it at the time of conception or subsequently?

The answer to this appears to be given by the facts connected with double and triple births. It is in the human race a law, without exception, that *twins embraced in the same chorion are of the same sex.* Three explanations of this fact suggest themselves: 1. They are of the same sex because they are nourished by the same maternal blood; but this fails, because then twins must always be of the same sex, which they are not. 2. They are of the same sex, because they are equally nourished from the same placental vessels; but this fails, because when one is amorphous, acephalous, or stunted, the sex remains the same. 3. That the sex was determined at the moment of conception; which is the only theory left. But what is true of twins, must be true of single births; therefore, we reach the decision that sex is fixed by the circumstances of conception. Such is the reasoning of Dr. Mayerhofer (*Von der Zeugung des Menschen*), and it seems conclusive.

The next question is, are the ovula or spermatozoa divided sexually, so that a given ovum, or spermatozoon can only produce one sex, or is it a matter which depends on the relative condition of the parents at the time of cohabitation?

The former theories have been often maintained. Prof. Schultze teaches that the ovula in the ovary are fitted, some to develop only male, others only female infants. The ancients thought that the secretion of the one testicle produced males, of the other females.

Both these and all similar theories cannot stand criticism. A very extensive and careful study of marriages, occurring over Germany, France and England, conducted by independent statisticians, leads directly to the formulating of the following rule: *Whichever party to coition is at the time in the fullest possession of his or her reproductive powers will determine in the embryo his or her sex.*

The facts are, that quite young men marrying women older than themselves, and quite old men, marrying vigorous women, both beget more girls than boys. Husbands, as a rule, being older and more vigorous than their wives, as a rule more boys than girls are born (106 boys : 100 girls). When those marriages are taken in which the husbands are all older, but not more than ten years older than their wives, the population of children is about 700 boys to 600 girls.

There is hardly any doubt that the physical condition of the parent at the time of conception influences the sex in the direction that the most

vigorous sex tends to perpetuate itself. It is part of this rule that when the male cohabits rarely, and thus has more vigorous and numerous spermatozoa, the children are more apt to be male. This is undoubtedly the case with lower mammalia, and may explain the fact that orthodox Jewish families have more boys than Christian ones, the male being restricted in the times of cohabitation by Leviticus, chapter xv, verses 19–28.

It is easy to misinterpret the facts in relation to this question. Quite recently, a writer in the London *Lancet* (Oct. 23d, 1880), maintained that sex is determined by the *relative ardency* of the two parents; a preponderance of impulse on the part of the male parent produces female offspring, while excess on the part of the female parent produces male progeny. Among the facts he alleges in support of this opinion, are the following: (*a*) The first children of quickly married parents are generally females. This is particularly noteworthy in the case of men marrying with a strong feeling of personal affection, or an especial desire for heirs. (*b*) Children born as the result of unions in which the female parent is not a consenting party, or is averse from the union, are almost invariably females. (*c*) Female children commonly resemble their male parents in early life, and at the successive periods of change occurring in the course of development and decadence. On the other hand, the offspring of unions, or periods, in which the female parent is the more ardent are nearly always males. (*a*) The first children of parents whose union has been long delayed, are generally males; so also are those of unions in which the male parent is not specially attached to the female. (*b*) The offspring of unions in which the desire of the male parent for an heir has become less ardent, while that of the female parent has increased, are generally males. (*c*) Children born under circumstances in which the female parent is the more exigent are, with rare exceptions, males.

Now, as we above stated, when the male is temperate in indulgence, either from lack of affection, absence or prudence, the spermatozoa are more vigorous and more apt to perpetuate the male sex; when the male exhausts the vigor of his secretion by repeated drains, the ovum gains the preponderance of power, and perpetuates its sex. We do not believe that a single one of the above facts proves that *ardency*, that the sexual passion, in other words, has *directly* anything to do with deciding the sex. It is a concomitant, not a cause. This mistake leads the writer in question to formulate a law almost the reverse of the one we are defending. His law is: "Granted a predominance of the procreative force on one side of the parentage, the offspring will be found of the *opposite* sex."

The simple fact he overlooks is that procreative force and sexual passion are not identicals but almost opposites. Yet a little reflection will convince any one that violent sexual passion almost always excludes procreation. Obstetricians know that a common cause of sterility is very frequent cohabitation (Billroth, *Handbuch der Frauen-Krankheiten*, Ab. vii, s. 60). Hence, it is not the preponderance of procreative force or the ardency of the one parent which leads to the children being opposite in sex, but it is the fact that the other parent, with less ardency, retains the force and expends the powers of the generative system, not in "a waste of passion," but in imprinting sex on the embryo.

Notes and Comments.

The Specific Agent of Typhoid Fever.

The *British Medical Journal* says that Professor Klebs, of Prague, believes that he has discovered the micro-organism which constitutes the specific agent of typhoid fever, and develops his views in a paper entitled "Der Ileotyphus eine Schistomycose," published in the *Archiv für Experimentale Pathologie*, t. xii, p. 231, 1880. Professor Klebs has for a long time, assisted by his pupils, been making researches in this direction. He writes that he has been able to find, at the necropsy of twenty-four persons carried off by dothinenteritis, microbes in various organs: in the intestinal mucous membrane, in the thickness of the cartilages of the larynx, in the pia mater, in the foci of lobular pneumonia, in the mesenteric ganglia, in the parenchymata of

the liver, and generally diffused in the organs which showed the most decided lesions. These micro-organisms showed themselves in the form of rods, about eighty micrometers in length and 0.5 to 0.6 micrometers in thickness. They have been constantly observed in the bodies of dothinenteric patients since the attention of Professor Klebs was drawn to the subject, and they are always absent from the organs, and specially the intestines, of subjects who have died from any other disease than typhoid.

The Contagium of Gonorrhœa.

Dr. W. Watson Cheyne published in one of the English journals, last July, a theory of gonorrhœa, which he attributes to the presence of organisms; and on this theory he based a plan of treating it with bougies of iodoform and eucalyptus oil, which, he stated, would remove the disease in a week or ten days.

There is nothing new in this theory, nor anything remarkably successful in the results. Dr. Neisser, in 1879, had a good deal to say about them (*Centralblatt für Med. Wiss.* No. 28); and Dr. Salisbury, years ago, claimed to have demonstrated them. In May, of this year, they were again described in a Hungarian journal by Dr. A. Bokai, who gives his investigations further in the *Allg. Med. Cent. Zeit.* (Sept. 15, 1880). The sum total of these studies is that micrococci are found in gonorrhœal pus; the gonorrhœal poison is supposed to be produced by them; but these micrococci do not *differ, either in form, size or any other visible characteristic, from* those found in non-infectious laudable pus.

This, we submit, is such a conclusion, that any calm investigator will continue to hold under doubt whether the micrococci have anything to do with the infection.

Cure of Grave Case of Hysteria by Simulation of the Operation of Spaying.

At the meeting of the Medical Society of Berlin, January 14th, 1880, reported in *Berlin Klin. Woch.* Dr. Israel reported the following case: A girl of 23, suffering from great pain in the region of the ovaries, with incoercible vomiting, which had reduced her to a very feeble state, was considered in so grave a condition that several of her physicians terrified her by proposing spaying as the sole means of relief. Finally, great preparations were made for the operation, the patient was put under the influence of an anæsthetic, and a large superficial incision was made in the region of the ovaries. The patient fully believed that the grave operation had been performed, and for several days complained of great pain in the abdomen; there was retention of urine for twelve days; but gradually the vomiting ceased, abnormal pain was no longer complained of, and the patient appears completely cured. This is another instance of the influence of imagination on hysterical complaints, an influence which Charcot considers of great account in most cases of hysteria uncomplicated with epilepsy.

Fetid Sweating of the Feet.

A simple and effective method of dealing with that annoying infirmity is suggested by a correspondent of the *British Medical Journal.* He says:—

All that is necessary is to strap the affected portions of the sole of the foot as smoothly as possible with tolerably wide straps of ordinary adhesive plaster—either emplastrum saponis or emplastrum plumbi. Every part should be completely covered, and with two layers of plaster if the complaint be very bad. The plaster should be taken off and renewed in three or four days, and once again at the expiration of a week, when the skin will be found to be quite healthy, having its normal yellowish appearance, and will also be quite dry. The odor ceases from the first application, and the patient will walk away in comfort. One may with confidence predict, even in the most severe case, a perfect cure in the time mentioned.

There seems to be in some persons a tendency to relapse after an interval of some weeks; but on the slightest sign of reappearance of the disease, it is only necessary to cover the patch with a single strap of plaster, which will at once arrest its progress, remove the fetor, and speedily exert its curative influence.

Health Rate of Foreign Cities.

In spite of its damp and raw climate, English cities are the most healthful in the world. In the second quarter of this year the annual rate of mortality in twenty of the largest English towns, having an aggregate population of about seven and a half millions of persons, averaged only 20.4 per 1000, whereas in twenty European cities the rate averaged 32.4. This remarkable excess in the death-rate signifies that the mortality in the European cities was 59 per cent. higher than that in the English cities, or, in other words, in equal numbers living, 159 died in the foreign cities to each 100 in the English

cities. This marked excess in the death-rate in the foreign cities is pretty constant. To be sure, Dublin shows a death-rate of nearly 40 per 1000, but Ireland is hardly to be counted in Great Britain when the general sanitary condition is under discussion.

Results of Marriages with Idiots.

Dr. Berkhan, in the *Zeit., für Psych.*, Vol. 37, makes some interesting observations as to the capabilities of microcephalic and other idiots to propagate their species. A semi-idiotic man has been married for some years to a healthy woman; there is no family. A healthy man, married to an idiotic wife, has had three children by her; two of them are idiots. These cases support Vogt's view, that while female idiots may bear children, the males are very frequently incapable of begetting them. Marriages are very rare between male half-cretins and healthy women, but are not uncommon between healthy men and semi-cretinous females who may happen to own a little property. The author has never seen the progeny of these marriages arrive at maturity; if not still-born, the children usually die during childhood.

Two New Anæsthetics.

The discovery of two new ænsthetics is announced by Dr. Edward Tauber, of Jena, in the *Centralblatt*, October 16. The one of these is methylchloroform. He tried it upon animals, and afterwards upon himself. Its action is very similar to that of chloroform, and it does not seem to possess any advantages over it. The second anæsthetic is also closely allied to chloroform, resembling it in odor, specific gravity and boiling point. Its effect, however, would appear to be more prompt and more temporary than chloroform. The chemical names of these substances are, respectively, monochloræthylidenchlorid and monochloræthyleuchlorid. These brief and convenient names will, no doubt, add to the popularity of these substances

---

Some Account of Resorcin.

This substance is chemically similar to carbolic acid. It has recently been attracting considerable attention as an antiseptic and antipyretic. Its chemical composition is $C_6 H_4 (H O)_2$. It is extremely soluble in water and in alcohol, and in odor it resembles phenol. Professor Biermer, of Breslau, reports some of the latest experiments with it. He gives it in doses from a half to one drachm hourly. It brought about a decided fall of temperature in fever patients, but of only temporary duration, and followed by an exacerbation of the fever. These large doses did not produce any symptoms of poisoning, but on the whole Professor Biermer advises against the use of the drug, as of doubtful value.

There is Death in the Pot.

These chemists are constantly discovering something to make one feel uncomfortable. Arsenic in the air of our rooms and germs in the water we drink, not to speak of lead in our wine and strychnine in our whisky, are bad enough; but here come Messieurs Brouardel and Boutmy, who communicate to the French Academy of Sciences the agreeable information that they have discovered an alkaloid resembling that extremely fatal poison, veratria, in a roast goose, bought that day in the market. They add, that such poisonous substances are sometimes formed in a few hours after death in the bodies of animals, and may at any time develop in edible meats!

Bloodless Excision of the Mammary Gland.

Several cases are reported by Dr. Leisrink, in the *Centralblatt für Chirurgie*, No. 30, 1880, in which he removed the mamma without the loss of a drop of blood! The patients had pendulous breasts, and hence, favorable for the operator. He prepared an apparatus, having two metal rods at the sides, and a movable cross-piece at each end. These cross-pieces could be screwed closely together. The breasts were first emptied of blood by pressure and manipulation, and then the apparatus adjusted. He found it much superior to any modification of the Esmarch bandage.

Hygienic Treatment of Varicocele.

Dr. P. Vautier, in a recent thesis, rejects the suspensory bandage in the treatment of varicocele, on the ground that it supersedes the natural support given to the testicles by the contractile dartos tunic and by the cremaster muscle, the tonic contraction of the latter especially aiding constantly in the emptying of the spermatic veins. These natural forces are lost if the parts be artificially supported, while the heat generated by the bandage also tends to prevent the scrotum from contracting. The author advises rather, in the early stages of the affection at least, prolonged rest in the horizontal position, varied by gymnastics or other moderately violent exercise.

Correspondence.

"Is Shampooing Advisable?"

Ed. Med. and Surg. Reporter:—

In your issue of November 13th a short article with the above heading is found, in which you quote Dr. Rumbold, from his treatise on "Catarrh," as saying that it is not; and me, from my recent treatise on "The Hair, its Care, Diseases and Treatment," as saying that it is, and ask that the question be brought to an issue.

The catarrhal side of the question was not mine to consider; it was the hair only that I was looking out for. Still, so far as catarrh is concerned, I can see no harm from a proper cleansing of the scalp surface. Shampooing, in the ordinary sense used, and including the barber's application of compounds, I do not consider healthful to the hair or scalp, if frequently applied. It is the remedy used, and the manner and time of using it that makes the barber "shampoo" unhygienic. They use, as a rule, *strong* alkaline solutions, sometimes fairly caustic in their action, then douse your head off with a hydrant attachment (no objection, if they *thoroughly* dried the scalp, so far as the hydrant is concerned, either hirsutically or catarrhally, so far as I can understand), and then send you out into the cold air, oftenest that of the evening, with damp, if not positively wet locks clinging to your head. Catarrh and scalp troubles could easily be brought about in this manner. Possibly this is the point Dr. Rumbold had specially in view.

In your article you say, "Dr. Leonard, in his book on the hair, recommends that it be washed several times a week with soap and water." This is hardly a fair statement, since frequent washing I only recommend in certain scalp diseases; and this only when the scalp can be thoroughly dried; and afterwards an oleaginous preparation is usually to be used. On pages 86 and 89, in the chapter devoted to the hygienic care of the hair, I say: "The adult scalp should be thoroughly washed *as often as once a month*, at the very least; a daily brushing will not suffice; brushing does not remove the oily particles from the scalp, except when dried down with dust and the scarf-scales of the skin.

"One of the best cleaning substances I know of, for either male or female to use, is the yolk of an egg. This should be well rubbed into the roots of the hair, and upon the scalp; then the whole washed out with tepid water and *Castile soap*, rinsing with clear, cold water. This done, it should be *thoroughly dried* by brisk rubbing with towels, so as to get a roseate glow to the scalp, thus bringing a larger supply of blood to the hair papillæ; if found too dry, a little pomade could be applied. The cocoanut oil is probably the best of any. Purified beef's marrow could also be made use of, though vegetable oils are the best to use, as they are less apt to become rancid."

In speaking of children's heads, in a preceding portion of the same chapter, referring to the general cause of eczema, I say: "This condition of affairs (milk crust, etc.) should not be allowed to take place, and it would not if proper attention were paid to the child's scalp. Washing the baby's head in lukewarm water, with Castile soap, twice or three times a week, or oftener if necessary, should be practiced from birth up; then a daily brushing of the hair should be made," etc.

Now, it is my opinion that a washing of the head, as above described, will have no tendency to produce catarrhal troubles; leastwise, it is most certainly beneficial to the scalp, and promotes the growth of the hair. In youth and childhood more sebaceous matter is poured out from the hair follicles than in adult life; hence, more frequent washing is then necessary. But the same precaution should be observed about getting into drafts of cold air until the hair is thoroughly dried, as in the case of adults. But no one more than I discountenances the frequent barber's "shampoo;" irritating materials are used for the lather; indeed, the lather is made at the expense of the oleaginous materials of the scalp; your scalp is but very imperfectly dried, and then you rush out into the cold air, to drive, or to walk about the streets to attend to your duties. Under such circumstances catarrhal troubles may well set in. Indeed, it is a wonder to me that we do not have more of them than we do.

This leads to the consideration of another point intimately connected with this, and that is *shaving*. Here catarrhal and quinsy troubles are apt to arise, in cold weather, when caution is not used. On page 312 of my hair treatise, I have also referred to this. The "closer" you shave the more chance you have for contracting neuralgia or catarrhal diseases, since at each shave you remove not only the hair, Nature's protector, but also the scarf-skin, in great measure, from your faces. It would be as sensible to leave off half of your woolen undershirt. No wonder you have sore throats, and the like, from such nonsense. I once practiced it, and regularly, Spring, Fall and Winter, I had a beautiful time with quinsy. I stopped shaving some seven years ago, and not an attack of quinsy since. Dozens of others, who have had the stamina to follow my advice, have also ceased to suffer from a like complaint.

But I am wandering from the subject directly in hand. In no place in my book have I recommended any other wash than Castile soap, the purest and mildest of all cleansing substances, as a hygienic measure. And then I have, and do, in my practice, insist that the hair shall be *thoroughly* dried before the usual tonic-dressing is applied. This tonic-dressing is oleaginous in its character, being made up of cocoanut oil, tr. cantharides, capsicum, nux vomica and bay rum, or Cologne water. Yours truly,

Detroit, Nov. 16, 1880. C. Henri Leonard.

The prescription for tonic is usually about as follows:—

℞.	Tr. cantharidis,		℥ ss	
	Tr. capsici,		℥ ss (j).	
	Ol. cocoæ,			
	Ol. ricini.	āā	℥ j	
	Spt. myristicæ,			
	Aq. Cologniensis, q. s.	ad	℥ iv.	M.

Sig.—Shake well.

Hair tonic. Apply once or twice daily.

News and Miscellany.

The Largest Man in America.

The largest man on this continent was the late Lewis Cornelius, of Pike County, Pa. He was considerably larger than Daniel Lambert. Mr. Cornelius' dimensions are entered upon the record books in the Prothonotary's office at Milford, Pike county, as follows:—

"Lewis Cornelius—Born 1794.
"Height, 6 feet.
"Circumference below waist, 8 feet 2 inches.
"Circumference above waist, 6 feet 2½ inches.
"Circumference of arm above elbow, 2 feet 2 inches.
"Circumference of arm below elbow, 1 foot 9 inches.
"Circumference of wrist, 1 foot 3 inch .
"Circumference of thigh, 4 feet 2 inch s.
"Circumference of calf of leg, 2 feet 7 inches.
"Circumference of ankle, 1 foot 7 inches.
"Weight, without any clothing whatever, 645½ pounds."

This is the only authentic record of Mr. Cornelius' size extant. As he had been sick some time, he lost over 50 pounds of his weight. He was not weighed until after his death, and when in full health would have tipped the scales at 700 pounds. His wife was a very slight woman, and weighed just 100 pounds.

The Tricycle.

The tricylce is recommended, in England to country physicians, instead of a horse. A clergyman writes of his tricycle:—

"I have traveled about 800 miles by this time, on pleasure trips in North Wales, and latterly in Derbyshire, on my work of deputation for the Society for the Propagation of the Gospel, and have found it a great comfort and pleasure. From seven to eight miles an hour is my speed, and I can do fifty miles per day. I can ride up any hill almost. I carry my portmanteau with me, and carried my boy, aged twelve, behind me for thirty-four miles once. If I were in a country place and wished to save a horse I should do so by keeping a tricycle. It wants no grooming, no corn, no tax, no gates. You can leave it at the door of a cottage and want no one to hold it, and, better than all, it has done my health (which was shattered abroad) more good than all the physic I have swallowed, and I cordially recommend it to both clergymen and physicians."

St. Mary's Hospital.

A special ward has been set apart by the management for the treatment of diseases of the eye and ear. The regular clinics for the treatment of diseases of the eye and ear are held on Tuesdays, Thursdays and Saturdays, at 3 P.M. H. Augustus Wilson, M.D., Attending Surgeon.

Back Numbers.

We will pay 20 cents each for a few copies of the Reporter, No. 1077; and 10 cents each for any of the following numbers: 1094, 1088, 1031, 1045, 1036, 932, 880, 879, 827, 672, 670, 562, 568, 561, 544, 524, 517, 503, 207, 185, 181.

Items.

—An old lady who has several unmarried daughters feeds them on fish diet, because it is rich in phosphorus, and phosphorus is the essential thing in making matches.

—Among the most hard-working young doctors of the Vienna hospitals is the Duke Charles Theodore, of Bavaria, brother of the Empress Elizabeth. He took his diploma some time ago and has practiced assiduously ever since. He is a regular attendant at the lectures of Professor Arlt, and is a clever operator.

—A gentleman went home the other night with a severe cold, and said to his wife, "I have to-day been told to take hot teas—pennyroyal tea, barley tea, baked lemon tea, beef tea, curry tea, hop tea, celery tea, liquorice tea, red pepper tea, baked onion tea, mint tea, hay tea, baked apple tea, and burnt sugar tea." "Well," said the sympathizing wife, "which do you think you will take?" "If you have no objections," said he, "I think I will take the hot gin sling."

QUERIES AND REPLIES.

Flatulent Dyspepsia.

Mr. Editor:—Can you or any of our friends tell me how to cure the distressing disease called "Flatulent Dyspepsia?" The writer has given nux vomica and glycerine a fair trial, with only partial results. The last named acted very satisfactorily upon the bowels, but caused distress while being digested. Any new light upon this old subject will be gratefully received by

Yours, respectfully, W. S. J.

Dr. V. S. of Pa.—The courts, both in this country and England, have decided that the relatives or heirs have no property right in the corpse of a deceased person. They have no right to sell it, nor can they obtain damages for a post-mortem examination made upon it.

On dit.—We should be pleased to receive and publish any items of personal information likely to interest the medical community.

MARRIAGES.

MARKS—HARPER.—On the 10th inst., by Rev. A. B. Maxwell, at the house of James Harper, Esq., R. T. Marks, M.D., and Miss Florence C. Harper, all of Leetonia, Ohio.

PHILLIPS—RHOADES.—On November 17th, 188', at the residence of the bride's parents, Cochranville, by Rev. W. Downey, pastor of Ebenezer M. E. Church, W. L. Phillips, M.D., of Philadelphia, and Miss Laura H. Rhoades, of Cochranville, Chester county, Pa.

REEVES—LEWRY.—On November 4th, 1880, by the Rev. Samuel Laird, at St. Mark's Evangelical Lutheran Church, Joseph M. Reeves, M.D., and Josephine Lewry, both of this city.

DEATHS.

BURMEISTER.—On the 15th instant, Dr. F. F. Burmeister, formerly Surgeon of the 69th Pennsylvania Regiment.

GERHARD.—Suddenly, on the 16th instant, Anne Gerhard, widow of the late William W. Gerhard, M.D.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1241.] PHILADELPHIA, DECEMBER 11, 1880. [Vol. XLIII.—No. 24.

Original Department.

Communications.

EXTIRPATION OF RECTUM, WITHOUT DESTROYING THE SPHINCTER ANI MUSCLE.

BY WILLIAM A. BYRD, M.D.,
Of Quincy, Ill.

The operation of extirpation of the rectum, or a portion thereof, for carcinomatous disease, or for stricture from other growths, has been given an impetus by the work and writings of Volkmann, in Germany, who has been followed by Drs. H. O. Walker, A. Van Derveer, Wm. H. Van Buren and others in this country, and chiefly by Mr. Harrison Cripps in England.

That the operation is destined to be of great benefit in relieving suffering and prolonging life will hardly admit of a doubt, when proper cases for the operation have been selected, and the operation performed with proper precautions.

The proper conditions would, with our present light, be that the disease should be epithelial, not too extensive and the patient not too much worn down. To the above, some authors add, that it has not involved the peritoneum, and is limited to the walls of the intestine. Two conditions that I must consider unnecessary to rigorously exclude.

As to the proper mode of excision, great care must be taken to guard against hemorrhage, which will be terrific and likely fatal if the ordinary scissors or knife be used to make the operation with. I insist the more on this from hearing a report upon surgery by Dr. Wm. Hill, of Bloomington, in this state, to the Illinois State Medical Society, at its last meeting. When he came to excision of the rectum he gave a graphic description of two such operations he had witnessed a capable and distinguished surgeon perform, in each of which, just before the end of the operation, to use his own words as nearly as I can recollect them, "at this stage of the operation death stepped in and drew the curtain on the bloody drama."

That the operation, as generally performed, includes the extirpation of the sphincter, and to that extent causes great inconvenience to the patient and more or less disgust to those who are brought in the immediate vicinity of the patient, on account of his or her partial inability to retain the fæces, is undeniable, and that fact has influenced me, in my operations, to endeavor to preserve the muscle for future usefulness.

Before relating cases, it will be as well to consider the mode of getting at such growths, some course of manipulation that would be apt to be of use in the majority of cases requiring the operation. The first thing to be done is to thoroughly dilate the rectum, dilate until the sphincter's muscular fibres give way and part like the fibres of a green stick when fractured. When this is properly and efficiently done, the bowel can be turned down, like rolling back the cuff of a coat sleeve, and a goodly part of the mass brought external to the body, permitting easy manipulation. To any one who has not tried dilation to that extent, the operation may look dangerous and liable to cause lasting paralysis of the muscle, with as deplorable after results as would follow the extirpation of the muscle; but I will state that for twelve years I have been practicing it in all cases of internal hemorrhoids, fissure of anus, and fistula, that I have been called on to treat,

and find that the paralysis only lasts for a few days, just about long enough to permit free drainage and the passage of fæces without pain or irritation. After the dilatation the rectum is to be held open by assistants, with stout wire loops bent into the shape of Sims' specula.

It sometimes happens that during dilatation the morbid mass splits longitudinally, nearly, if not quite down to the underlying connective tissue; this fissure being generally located along the centre of the neoplasm, may be taken advantage of, and the growth removed by seizing the upper portion of each mass with forceps or double tenacula, and separating the neoplastic from the healthy tissue by passing the white-hot wire of a galvano-cautery along at the point of union of the two tissues, touching lightly, as with a scalpel in making a nice dissection. Thus, by working carefully downward and outward from the fissure, the neoplasm is removed with little hemorrhage and in a short time; especially is this true if the disease is limited to the tissues of the gut proper.

Unfortunately, the disease is not always limited by the connective tissue external to the bowel; then the proper amount of pressure cannot be brought to bear so well with a galvano-cautery as with Paquelin's thermo-cautery, with which the growth should be bisected, if it does not fissure from the force of dilatation, and the same process followed as described above; except where prolongations extend deeply in the tissues they should be followed up and destroyed with the point of the thermo-cautery, or scraped away with Sims' or Simon's sharp curette. The latter instruments are not so good to use as the actual cautery, on account of the greater hemorrhage.

As to a slight involvement of the peritoneum, I see no good reason—in the light that the number of successful cases of removal of the cervix uteri and morbid growths of the uterus, where that membrane has been opened without harm, although accidentally done, has shown us—why the operation should not be undertaken and successfully carried out. I, at least, do not think such a condition would deter me from giving the patient the benefit that I believe would so almost certainly follow the successful carrying out of the operation. In such a case it would be well to pass a drainage tube into the peritoneal cavity a short distance, and unite the edges of the peritoneal wound, except where the tube entered, carefully, with sutures of cat-gut, metallic or Dr. Pancoast's black silk. Sutures I have never used, believing that they would defeat one of the objects of thorough dilatation.

Upon this point I find Dr. A. Van Derveer, of Albany, N. Y., fully agrees with me, and, in regard to that I will quote from a very good article written by him for Vol. xvi, 1879, New York *Medical Record*, entitled "Report of Two Cases of Excision of the Rectum, with Remarks." He says:—

"I think there is much yet to be considered regarding the use of sutures. The principal causes of death in this operation have been pyæmia, pelvic cellulitis, and peritonitis. With this knowledge in our possession, is it not safe to do away entirely with sutures, give free exit to the wound by the aid of a drainage tube and frequent washing out, keeping the parts in an antiseptic condition, and avoid the possible danger there is in the sutures, closing the parts in such a manner as to cause the pus to be retained, and thus most certainly produce some of the results that are known to be fatal? I should like a fair, candid expression from the surgeons who have done this operation, as to how much service the sutures have been in holding the rectum down to the cutaneous surface, and whether, in the majority of cases, they have not torn out before primary union could possibly occur." The whole article will well repay perusal, as will also a lecture by Dr. W. H. Van Buren, in Vol. xiv, 1878, of the New York *Medical Record*, entitled, "Extirpatio Recti (Volkmann) for Cancer, with Cases." Dr. Van Buren's lecture treats the subject more methodically, of course, than I expect to in this short paper, or by Dr. Van Derveer, in his report.

After the operation it is well to evenly pack the wounded surface with something that will prevent hemorrhage by giving even, steady support. Some surgeons use a large sponge passed up above the incisions and pack the space below with smaller sponges. This plan I have tried, but a better plan would be to use the folds of a roller bandage made of cheese cloth, and thoroughly soaked in glycerine; this should be packed, as it is unrolled, around a rubber catheter passed well up the bowel; the end hanging out at the anus permits its ready removal.

The catheter should not be omitted, as it permits the free passage of gases as they are generated.

The bandage tampon I first used in operations upon the uterus, and was so well pleased with the facility of its application and removal that I now use it for tamping in all cavities where a tampon is needed. The saturating of the tampon with glycerine should not be omitted, as it acts as an antiseptic; also prevents undue

swelling of the parts from the flow of the fluids from the surrounding tissues, owing to its affinity for water. Its antiseptic qualities any one in general practice can soon prove by using a vaginal tampon, either dry or moistened with water, and one saturated with glycerine; if the two first are taken out at the expiration of twelve hours, they will be found very offensive; the one saturated with glycerine at the end of that time will give out no odor, and at the end of forty-eight hours will be scarcely as offensive as those not so treated are in twelve hours.

The tampon should be removed in about twelve hours, as by that time there will have been sufficient plasma thrown out in the tissues to check any tendency to hemorrhage.

Dr. Van Buren recommends that the tampon be made with a soft, easily distensible, India-rubber bag, working on the same principle as a Barnes' dilator, having a catheter or tube passing through it to the cavity of the bowel, to permit the escape of gas. This will not act as well as the folded bandage and glycerine, as it will prevent the escape of fluids that readily become septic and prevents any means being used against their decomposition, which is met by the glycerine in the other method.

Of course, there are other means of extirpation, such as the ecraseur, and serrated scissors, but the actual cautery is so superior that they should not be considered if it is at all possible for the surgeon to avail himself of the means of applying the actual cautery.

I stated, in the beginning, the benefits to be derived from this operation would not admit of a doubt, which statement, perhaps, had better be modified to read, by the majority of surgeons. So judicious a surgeon and able a teacher as Dr. John Ashhurst, Jr., in the second edition of his "Principles and Practice of Surgery," page 818, in writing of malignant stricture of the rectum, writes: "The treatment must be merely palliative; any attempt to excise or tear away the malignant growth being, in my judgment, totally unjustifiable, and usually leading to a speedy death from peritonitis or hemorrhage. Pain is to be alleviated by the free use of anodynes, by suppository or otherwise, and fecal accumulation to be prevented by the occasional use of laxatives. Emollient enemata may sometimes afford relief, but great care must be taken in their employment, not to inflict injury on the bowel. Bougies may be cautiously employed before ulceration has begun, but at a later period could only be productive of mischief. Linear rectotomy is recommended by Verneuil, but I confess it seems to me not a very promising mode of treatment, and I must say the same of Volkmann's proposal to remove the growth with a circular portion of the rectum and stitch together the divided portions of the bowel. Finally, lumbar colotomy may be properly resorted to, either to relieve obstruction or to obviate the suffering caused by the passage of fæces over the ulcerated surface."

But to illustrate the advantages, I will report two cases; the first of which was published in an article of mine entitled "Clinical Notes upon the Use of the Galvano-cautery," in the *Independent Practitioner*, of Baltimore, for January, 1880.

Case 1.—"Mrs. Philip B., aged sixty-one, was sent to me by Dr. S. W. Durant, of Adams, Illinois, to have an operation performed to give her relief from pain, loss of blood and tenesmus during defecation. I sent her to St. Mary's Hospital. An examination revealed, an inch and a half up the rectum, an indurated, nodulated mass, of half an inch or more in thickness, occupying the bowel and infiltrated in its coats for two inches. The opening through this mass would barely admit the passage, with some force, of the index finger, and was ulcerated throughout. From the ulcerated surfaces came a good deal of pus and blood when hardened fæces were forced through the small opening. Dr. Durant was of the opinion that the stricture was of a malignant nature.

"I determined to remove the strictured portion of the bowel with the curette and the caustic wire, through dilating the sphincters, thereby saving those muscles for future use.

"February 25th, 1879, with the assistance of Drs. J. F. Durant, M. Rooney, M. Penick and J. A. Wagner, with the patient under ether, I introduced my hand, as a divulsor, into the rectum and through the stricture. The rectum was then held open with wire-loop specula, while I scraped the softest portions of the growth with a Sims' sharp uterine curette. The hard nodules were lifted with forceps and held terse while the heated wire was thrown around and cut through below their bases. All points where blood issued were well cauterized. There was great hemorrhage while using the curette.

"Warm injections of a solution of chloride of potassa were ordered every four hours, as an antiseptic. Anodynes were given as necessary, though she required but little, and tonics.

"Large-sized rectal bougies were passed daily, after the first week, to prevent the cicatrix from contracting so as to reproduce a stricture.

"March 25th, there being no ulceration nor discharge of pus or blood, or tenesmus, she was discharged. The cicatricial tissue that occupied the place of the tumor was not more than half an inch wide, was smooth, elastic, and had an opening through it of an inch and a half diameter.

"The tissues of the constricting mass were carefully examined under the microscope, but no evidence of malignancy was discovered.

"May 23d, she returned, complaining of difficulty in passing fæces if hardened, but free from hemorrhage or suppuration. The cicatricial tissue had contracted, leaving the calibre of the bowel not more than three-quarters of an inch in diameter. This, with the assistance of Dr. S. W. Durant, I dilated, under ether, with my hand, and ordered it to be kept open by the daily use of Wales' soft rubber dilators.

"August 1st, she returned, with constipation and trouble higher up the bowel, beyond my reach. With laxatives and tonics she improved, and is doing fairly well now; yet I believe that although we were unable to determine carcinoma, that disease is the trouble, and that she will yet die of it."

She only suffered pain preceding efforts to evacuate the bowels, that would come on about every three days, and that was obviated to great extent by the use of the fluid extract of cascara sagrada. She required but little morphia to allay the pain.

She died in August, 1880, having been fairly comfortable up to within a few weeks of her death, when she died of exhaustion, and presumable amyloid degeneration of the kidneys, from the long continued suppuration.

This case might be cited by the opponents of the operation as proving the inutility of it, but it must be remembered that she lived for a year and a half after the operation, in a state of comparative comfort, being able to attend to her domestic duties most of the time.

It may be possible that a localized pelvic peritonitis existed, causing adhesions or bands of false membrane to obstruct a portion of the small intestine, a surmise justified by the fact that the smaller size of Hale's dilators could be passed into the colon for eighteen inches. As she died out of the city I was unable to make an autopsy.

Case 2.—March 24th, 1880, I was called by Dr. A. L. Fox-Rooney, to see Mrs. T. P., a lady of fine physique, aged forty-three, who had been suffering with what she supposed to be hemorrhoids, for over a year. Upon examination a nodulated, warty-like mass was found, one inch from the anus, occupying about three-fourths of the calibre of the rectum, posteriorly and laterally. This had been diagnosed by the Doctor to be epithelioma, in which I agreed with him and advised extirpation. The next day the operation was performed, with the assistance of Drs. A. L. Fox-Rooney and Michael Rooney. The sphincters were first fully dilated and the mass removed as described above, with the galvanocautery. There was considerable hemorrhage, which was stopped with the cautery and a tampon applied. After the tampon was removed antiseptic injections were used, of a warm saturated solution of chlorate of potassa, an agent I consider far superior to carbolic acid in operations upon the lower bowels, on account of its freedom from danger through absorption.

The microscope revealed the fact that the growth was epithelioma.

Under the careful and judicious treatment of Dr. Fox-Rooney the lady made a rapid recovery and has had no indications of a return of the disease up to the present time, and I believe I may truly say that she is cured.

In neither of these cases were any sutures, nor any other means to obtain union by first intention used, as I believe with Dr. Van Derveer, as above, and with Dr. W. W. Dawson, of Cincinnati, who teaches that patients recover better after operations for epithelioma by allowing free suppuration from the surface from whence the growth is removed.

If I have contributed in the least in establishing this operation upon a scientific basis, or the stimulating of abler surgeons to do so, I shall feel abundantly repaid for the time spent in preparing this article.

407 *Jersey st.*, *Quincy*, *Illinois*, *Nov.* 22, 1880.

DEAFNESS AS THE RESULT OF THE POISON OF SYPHILIS.

Presented to the Sub-section of Otology, of the British Medical Association, at its Meeting at Cambridge, England, August, 1880,

BY LAURENCE TURNBULL, M.D., PH.G.,

Aural Surgeon to Jefferson Medical College Hospital, Philadelphia.

The number of cases of syphilitic disease of the ear are much less numerous in the United States than in Great Britain, or on the continent. This fact I have proven by repeated visits and examinations of hospitals, and clinics, both public and private, of Europe. I also quote the careful observations of one of their distinguished aural surgeons, Dr. Dalby. He states, in the *Lancet*,

of February, 1877, "Next to scarlet fever, inherited syphilis may be reckoned as the most fruitful cause of deaf muteism."

In the United States, in a practice extending over twenty-four years, in a city of nearly one million inhabitants, the proportion of cases of syphilitic disease of the ear, is about sixteen in one thousand, while in my public clinic at Jefferson College Hospital the number within the last three years shows a decrease as compared with my private record. This fact is in part owing to the greater amount of care and time given to the histories of the cases in my private record, which includes investigation into heredity, etc. The same facts are proven by reference to the statistics of the Institutions for the Instruction of Deaf Mutes in the United States. By examining their reports, it will be found that next to scarlet fever, the largest number of non-congenital deaf mute cases are placed under spotted fever, a low form of typhus, or continued fever; then follows in order of frequency cerebro-spinal meningitis. This, however, may arise from the fact that but very few of the superintendents are medical men, and therefore, are not competent to judge of the histories accompanying the pupil, which they often receive, not from the family physician, but from ignorant parents, guardians, or friends. In further evidence of what has been already stated, in a total of fifty deaf mutes, nineteen were congenital, eight the result of scarlet fever, twelve of spotted fever, one each of typhoid, intermittent and catarrh, while six were under the indefinite head of "disease of the brain, or ears." It is well known that heredito-syphilitic affections of the ears may cause deaf-muteism, from the poison affecting the brain, causing disease of the labyrinth, semi-circular canals, etc., and in some cases is ushered in by what is now known as Ménieré's class of symptoms; such as headache, nausea, vomiting, dizziness, or staggering gait (to the right or left), and terminating in profound deafness.

The first indication of the disease of the brain may, however, show itself in the eyes, as strabismus, interstitial keratitis, or exudative or serous iritis, or irido-choroiditis.

In regard to the sexes, it has been found that inherited syphilitic disease of the ear affects chiefly females, and the larger proportion are young, from infancy up to womanhood. There are less adult males than females.

Diagnosis.—Often at a glance the syphilitic affections of the external ear, soft palate, or pharynx, are recognized by dull pain in the ear and by the peculiar form of mucous patches; but it is much more difficult, without a very careful and prolonged examination, with a history of the case, to be certain that syphilis is the chief cause in obscure disease of the middle or internal ear. One great advance in diagnosis is by aid of the tuning fork, which indicates the bone conduction, a subject which has of late years received a considerable amount of attention, and has been summed up by Prof. Hensen.* "As the bone-conduction unquestionably in a very considerable degree enters the labyrinth through the apparatus of the drum-cavity, this process may appropriately be termed cranio-tympanic conduction. How far direct bone-conduction produces auditory sensations is still unknown."

We feel sure, from our numerous experiments in cases where the auditory meatus has either been injured or entirely closed, or from loss of the ossicles and membrana tympani, there is no direct hearing of any sound whatever by the tympanic avenue, so far as we can judge by the watch, voice, etc. Yet such individual cases as, for instance, the deaf mute, if free from diseases of the bones, have the power of receiving impressions of sounds by means of the teeth and by aid of the audiphone and tuning fork, but not perfect articulate speech.†

Dr. Knapp, in support of this hypothesis of Hensen, states that bone-conduction conveys only quantitative, not qualitative impressions of sound to the acoustic nerve, and mentions the following observations: (1) "He never found a person who could hear his watch (of 24″ hearing distance) from any part of the skull if he could not hear it on contact with the auricle." (2) The audiphone, in his experience, never increased the hearing power more than a trumpet, commonly very much less. (3) Patients with acute otitis media, who could not hear the watch when applied to any part of the skull, and who had only quantitative perception of sound, *e. g.*, heard only an indefinite sound when words were hallooed into their ears, immediately after inflation by Politzer's method, heard the watch by bone-conduction and understood what was said from 5′ to 15′. Dr. Knapp considered it evident that the bone-conduction, which was evidently preserved in such cases, is of itself insufficient to convey qualitative perception of sound. See our paper in support of the above.†

* Vol. III, Part 2, *Herman's Handbuch der Physiologie. Archives of Otology*, Vol. IX, No. 3, Page 272.

†*College and Clinical Record*, Philadelphia, March 15, 1880, page 43. Also, "A Comparison between the Audiphone, Dentaphone, etc., and the Various Forms of Ear Trumpets for the Deaf." Philadelphia *Medical Times*, August 28, 1880.

HISTORY.

As early as June, 1853, Wilde, of Dublin, published the most distinct account of syphilitic affections of the ear, in his work on Diseases of the Ear; but he unfortunately dwelt too much upon the local manifestations occurring in the membranes of the tympanal cavity, while he neglected the nervous element. The same syphilitic poison which produces alternately an affection of the eye and ear was termed by Sir William "an inflammatory affection." In the work of Joseph Toynbee but little information is given concerning syphilitic affections of the ear, but this was remedied in the edition issued in 1868, with a supplement, by the late James Hinton, Aural Surgeon to Guy's Hospital, who must have seen a large number of cases, because he states that "more than one-twentieth of the aural outdoor patients present the now familiar aspect of hereditary syphilis, and have, in every case he has met with, suffered from impaired vision before the deafness has arisen." He further observes: "I know no other affection, except fever, which in a person under twenty brings on deafness so rapid and so nearly complete." In the course of a few weeks a girl, previously hearing well, will, without pain or known cause, become unable to distinguish words. Perhaps her eyes, which have been long inflamed, have about the same time become better. On examination, it is found that a tuning fork placed on the head is heard for a very short time, or not at all; the meatus is free from wax, the membrana tympani looks somewhat white and rough—it may be flat or concave, but it generally has a dried-up look, as if its fluids were deficient; the Eustachian tube may or may not be pervious. From the symptoms, however, it is evident that, as in the case of the eye, both the conducting and the nervous apparatus are liable to be involved in this disease. The peculiarly harsh sound produced by passing air into the tympanum suggests the presence there of rough, rigid lymph, and the total deafness proves that the labyrinth has suffered." In his more recent work, "The Questions of Aural Surgery," 1874, Hinton states: "Syphilis has a certain part in aural disease, but how large a part is not yet decided. Its influence is most marked in its hereditary form, as pointed out by Mr. Jonathan Hutchinson, in his Clinical Memoir on Certain Diseases of the Eye and Ear. Every now and then deafness seems a feature of syphilitic sore throat; but if this is a frequent occurrence the specialist does not see much of it." Again he states that "it seems to me that of aural affections probably traceable to syphilis, the most frequent are obscure affections of the temporal bone, occurring long after the primary disease, and giving rise to anomalous symptoms, chiefly of nervous character. The next important authority is Von Tröltsch, who only treats of syphilis as a cause of nervous disease of the ear. "We often find in persons whose hearing is impaired, and who have formerly suffered from constitutional syphilis, and especially children of syphilitic parents, that the impairment of hearing tones through the bones of the head is not in perfect accord with the amount of trouble in hearing conversation."

Up to this period but little attention was devoted to this form of disease of the ear, and but very few cases were successfully cured.

(To be Continued.)

FIBROID TUMOR OF THE WOMB—RADICAL CURE BY THE USE OF ERGOT.

BY F. L. MARSH, M.D.,
Of Mount Pleasant, Pa.

Mrs. M., multiparæ, aged thirty-seven, began about four years ago to lose a great deal of blood at her menstrual periods. Later, her losses of blood were at very short intervals.

On the 21st of September, 1879, I was first sent for. I found her in a very exhausted condition; hemorrhage profuse, pulse scarcely perceptible, and, in fact, in imminent danger of dying. Upon examination I found an enlarged womb, the sound passing four and a half inches along the anterior uterine wall, but meeting with an obstruction in the posterior. I at once tamponed the vagina, gave stimulants, and before leaving my patient, administered, hypodermically, two grains of ergotine.

September 22d. The os not being sufficiently open, a further examination, after dilating the neck with sponge tents, revealed an interstitial fibroid, occupying almost the whole posterior wall and fundus.

I was tempted at this time to incise the capsule, but she being a timid woman, and very adverse to an operation, I concluded to put her on the use of ergot, in order to bring the tumor nearer operative reach. I injected again, hypodermically, one grain of ergotine, and continued the use of the drug in this way once in twenty-four hours for one week. On account of pain produced by the needle she objected to the further use by that method.

I then ordered her fl. ext. ergot and potassium bromide, twenty drops of the former and

ten grains of the latter, three times daily, before meals.

Three months later the hemorrhage was materially lessened, and an examination of the uterus indicated the tumor smaller in size. After this she took daily from sixty to ninety drops of ergot, and thirty grains of the bromide, for ten months longer, when the hemorrhage had entirely ceased, and the tumor, which had been growing smaller from time to time, was found to have entirely disappeared. Her general condition improved rapidly. The uterine measurement shows the womb normal in size.

This case demonstrated to my mind the possibility of total absorption of uterine fibroids by the long continued use of ergot.

The objection might be entertained that perhaps there was a mistake, and that some other condition may have existed, susceptible of being absorbed, or that the tumor might have been expelled.

I am positive, however, as to my diagnosis, and satisfied myself completely that no portion of the tumor passed from the vagina. One other supposition is, that the tumor may have become subperitoneal. A careful examination excludes that.

During the last five years I have treated eight cases of uterine fibroids. Ergot was administered in all, with the view of lessening hemorrhage and facilitating operative measures. In two cases of sub-mucous fibroids, especially, was the effect of the drug manifest by the ergotic contraction of the womb, and the consequent squeezing of the tumor through the os uteri. In each case the tumor was wholly removed by the usual surgical methods, but one. The lady in question, having been exhausted by the repeated bleeding, died suddenly, two weeks after a partial removal of the tumor, from the symptoms of heart-clot.

Hospital Reports.

PENNSYLVANIA HOSPITAL.

SERVICE OF DR. JAMES H. HUTCHINSON.

Reported by Dr. George F. Souwers.

Gentlemen:—There is a class of urinary affections which, on account of the uncertainty of their cause, pathology, and, I may also add, treatment, is of peculiar interest to the physician. Although marked by an excessive flow of urine they are not really dependent upon disease of the kidneys—the alterations which are occasionally found in these organs after death being due to derangement caused by their increased functional activity—and are, therefore, to be regarded as results rather than causes of the malady. Occasionally following quickly upon the occurrence of injuries to the head, they have more frequently an idiopathic origin; their cause being often unknown or obscure.

I refer to the conditions known as polyuria or diabetes insipidus, as it is more commonly called, and diabetes mellitus, or that form of polyuria characterized by the presence of sugar in the urine. In illustration of my remarks I introduce to your notice E. O., aged 48, a widow, and a domestic by occupation. She was admitted to the house October 18th, 1880, and has since been under treatment. She tells us that her father died of phthisis, but that her mother and brother are still living and healthy; she, too, was robust up to the time of her marriage, when she was 16 years of age. Within a few months of her marriage she suffered three miscarriages, each time losing a large amount of blood and being greatly debilitated, and for several years after she was the victim of uterine disease. She has had, since her marriage, six children and seven miscarriages, her last pregnancy, ten years ago, terminating in this unfortunate manner. Nearly all her miscarriages were caused by overexertion. The menses were regular till thirteen months ago, when they stopped for three months, and since that time have been very irregular. Since childhood she has been the subject of a dry cough, but has never had hæmoptysis or night sweats. For many years past she has had slight dyspnœa and palpitation of the heart, both of which have gradually been getting worse. She frequently has nervous headache and vertigo, and suffers constantly from constipation. She further tells us that her husband frequently struck and ill-used her. Her present trouble began about three years ago, large quantities of water being then passed. At the time of her admission to the ward she was compelled to rise eight or ten times during the night to pass her urine, which, before morning, half filled an ordinary bucket. Her feet, in the early portion of her disease, were œdematous, but this symptom has not been present now for several months past. Since her illness she has lost a great deal of flesh, and has felt, and now feels, weak and miserable. She suffers from a constant thirst, to allay which she consumes very large quantities of fluids. During the past summer, while employed at the sea-shore, she had a number of slight rigors, followed by marked jaundice. On admission, this jaundice was still present, the conjunctiva and skin being stained a deep yellow color; the tongue was flabby, and the intellect dull. She complained that her memory seemed to be rapidly failing. On examination the urine was found to be clear, to have a specific gravity of 1.008, to contain a slight amount of albumen, which has never been detected since, but no sugar, and to be acid in reaction.

On account of her anæmic and debilitated condition she was at once put on a tonic regimen, quinine, tincture nux vomica, ten drops, and tincture gent. co., one fluid drachm, being administered three times a day.

Now, in this disease we have presented the, to some extent, opposite condition to that present

in diabetes mellitus, for while in the latter condition large amounts of urine are passed, there is always present more or less sugar; in the form under discussion large amounts of water only are excreted. I will show you one of the tests which demonstrate that there is no sugar present in the urine. This test is made by means of what is known as Fehling's solution, a mixture being made of 534 and a fraction grains of sulphate of copper in 3016 grains of water; to this is added a solution of the neutral tartrate of soda, 2669 grains, and caustic soda, 7715 grains, and finally a pint of water. A small amount of this solution is boiled in a test-tube and then the suspected urine is added drop by drop; if sugar be present in any amount the sub-oxide of copper is precipitated. The question might naturally arise here, are there no other diseased conditions that will give rise, either to an augmented quantity, of a higher or lower specific gravity, or a saccharine condition of the urine? I must answer that there most certainly are such conditions, but that when present the phenomena are but transient; thus, after an hysterical attack there is very apt to be an augmented flow of urine, of low specific gravity. Asthmatic attacks and a fright, or sudden excitement, are followed by an increased discharge of urine, but in the case under consideration we have no such factors to deal with, and instead of being of a transitory character, the diseased action has now lasted three years, so that undoubtedly we have before us a case of polyuria. Before discussing the treatment which was ultimately pursued in this case, and which, I am happy to say, has given satisfactory results, I will say a few words to you on the exciting causes and the prognosis of such cases.

Dr. Roberts has tabulated the history of seventy-two cases of diabetes insipidus; among the seventy-two we find that injuries of different kinds to the head were accountable for six, and that disease of the brain produced the peculiar symptoms of the disease, or, at least, was present, in five others. In all the others no satisfactory cause could be ascertained. It is a well known fact, however, that sunstroke, or excess of any kind, especially venereal excesses, are prominent factors in the production of the disease. Care and anxiety are chargeable, I think, for a large number of the cases of this trouble. That the disease is of nervous origin, I believe has been repeatedly demonstrated, but exactly how this constant drain of nervous energy produced by worry and anxiety acts I am not prepared to say. Now, in the case before us, for instance, we have no history of injury of any sort to the head; the brain evidently is not the seat of any gross disease, for though, when examined ophthalmoscopically, the background of the eye presents a few spots, which may possibly be due to very minute hemorrhages, no white patches, no retinitis, and no choking of the disk were discovered. The history shows, however, that the woman has been the victim of much bad treatment at the hands of her husband; that a hard life and frequent miscarriages have reduced the stamina of her constitution, and that, taking one thing and another, she has for many years been constantly worried and anxious. I have seen a number of cases of polyuria having just such an antecedent history.

The prognosis of these cases is, and yet is not favorable. It is favorable in that the disease itself does not kill directly; thus no case in our wards has ever proved fatal from the passage of the large amounts of urine per se; at the same time I only at present remember one case in which recovery eventually took place as a result of treatment. The tendency of the disease is not to recovery but to persistence. The patient is gradually weakened, not by the large amount of water passed at any one time, or series of times, but by the constant quantity, though small, of solid matter which is passed, or we may say, drained away from the system.

Treatment, as I have already intimated, as a rule, exercises little or no control over the course of the disease. There have been quite a series of drugs employed by the profession in striving to afford relief to patients; of these we may mention valerian, which in those cases of polyuria owing their origin to hysterical attacks has undoubtedly afforded relief to the patient, not, probably, by any direct action on the morbid condition, but by its serving to calm and allay the irritable nervous condition upon which the hysteria depends; asafœtida has also been employed, but is very far from being a specific. Some years since, in a case of this disease which came under my notice, and in which various other remedies had already been employed unsuccessfully, ergot was given, more to study its effect, and as an experiment, than from any positive hope being entertained that it would prove of use in the disorder. It was, however, found to afford very decided relief to the patient, in fact he remained permanently well after its use as long as he continued under observation. As a number of remedies had already been employed unsuccessfully in the case of the woman before you, before she came under my care, it occurred to me to place her upon the use of this drug. In the case to which I referred just now it was administered hypodermically, but in this one I decided to employ the fluid extract. At first, half a drachm was administered three times a day, but this dose was gradually increased during the next few days until a full drachm was given. Under its use the amount of urine passed by the patient has most certainly diminished, as she now has to rise but three times during the night to micturate, and instead of passing half a bucketful of water, she passed last night but three-quarters of a pint, a quantity which is, however, less than the average of the last few nights. Still I would not teach you that ergot is a specific for the disease, nor even that it will afford partial relief in all cases, for my experience in its use does not yet warrant me in making any such statement.

There is another phase of this case which I would also like to call to your attention. Over different portions of her body we find slightly elevated petechiæ, that are the seat of intense itching; I do not think, from their appearance, that they are caused by the presence of parasites, but whether or not they are a manifestation of polyuria, I am not prepared to say. Washing with liquor carbolici exerts a soothing influence on the itching sensation.

Medical Societies.

THE TRI STATES MEDICAL SOCIETY.

Sixth Annual Meeting, held in Louisville, Ky., Nov. 9th, 10th, 11th, and 12th, 1880.

Reported for the Medical and Surgical Reporter, by A. H. Kelch, M.D.

(*Concluded from page* 498).

The afternoon session was opened by the exhibition and explanation of the *phacometer*, an instrument for testing the refracting power of lenses, and adapted to any character of lens, by Dr. D. S. Reynolds, of Louisville.

The instrument exhibited was that known as Snellen's Phacometer. The improvements added by Dr. Reynolds consist in a dial plate graded in degrees, upon which the luminous impression enables the observer to recognize at a glance the axes of cylindrical surfaces. With this attachment it is the work of but an instant to slide the dial upon which the cross lines of luminous points are focused, in order to determine the refracting powers and the axes of compound cylindrical lenses. To overcome the inconvenience of being obliged to have the instrument in a darkened room, Messrs Cook and Sloss, of this city, have added a telescopic bellows attachment, which is fastened between the lens and the centre of the beam and to the rim of the registering glass or dial plate. The box covering extends from the lamp at the distal end of the beam up to the centre, and there are two movable arms upon which the frames of the spectacles may be raised to secure uniform relations between the glass to be measured and the image produced upon the indicator.

Another improvement consists in the introduction of a spring attachment to the clamp designed to hold the lenses for measurement. This allows the body of the clamps to recede in opening, and come together by the aid of a weak spring which is sufficient to make the jaws of the clasp hold the lens firmly.

Dr. Reynolds made the somewhat startling announcement that even the lenses found in oculists' test cases, made by the most celebrated manufacturers, are not correctly graded, many of them possessing refracting powers widely different from that represented by the figures etched upon the margins of the lenses. The spectacle lenses in ordinary use, and for sale by jewelers and merchants generally who deal in notions, very rarely represent an amount of refracting power equal to any particular point in any graded system. They are rarely symmetrical, in consequence of having different refracting powers in different portions or meridians of the lenses.

To test this a number of gentlemen present handed their glasses to Dr. Reynolds, who, upon introducing them into the Phacometer, found that in some of the lenses half a space more of refracting power existed in one meridian than in the meridian at right angles. Among several spectacles examined but one pair of correctly graded lenses were found, thus showing the immense value of the instrument for testing all sorts of spectacle lenses.

An incredulous specialist in the audience submitted his lenses for examination, and almost in an instant Dr. Reynolds announced that the lenses were compound cylinders, that they were not alike in each eye, and that the difference amounted to but a single space, and stated the combination in each lens, greatly to the surprise of the gentleman who wore them.

Dr. J. R. Weist, of Richmond, Ind., next read a paper on the subject of "Bronchotomy for the extraction of foreign bodies in air passages." Under the term Bronchotomy, all the operations for opening the trachea or larynx were included. Dr. Weist considered the standing of the operation among surgeons from early antiquity, and adds, that since 1854, surgeons have generally accepted the conclusions reached by Dr. Gross, "that inasmuch as no confidence is to be placed in the efforts of nature to effect the removal of foreign bodies, and inasmuch as no patient can be considered safe as long as a foreign body remains in the air passages, it follows, as a necessary corollary, that bronchotomy offers the best chance for relief, and it ought to be resorted to as early as possible, unless there is some contra-indication." Dr. Weist cited several other authorities to show that the rule is established, that "when there is a foreign body in the air passages, bronchotomy ought to be performed. The surgeons quoted, he adds, base their advice on statistical reports, for, as Prof. Gross says in reference to these cases, 'individual experience amounts to nothing, collective experience is everything, and the statistics seem to show a much lower rate of mortality among those operated upon than among those left to the chances of expulsion by natural causes and processes."

The statistics of Dr. Gross were then given, which showed that the mortality among those cases left to the efforts of nature was nearly twice as great as that among those who had been subjected to bronchotomy, and these facts, therefore, justified the operation.

Some years since, continued Dr. Weist, I made a collection of cases, the study of which gives results at variance with the reports of Professor Gross. My tables were obtained almost entirely through the medium of a circular distributed among medical men, and they contain the material facts in reference to 878 cases of foreign bodies in the air passages. Of these, 700 had never been reported, and 500 had not been subjected to bronchotomy, and leaving all cases in which the body had been removed by simple means, the remainder showed a mortality of 25 per cent. Dr. Weist says, it remains to be seen what conclusions can be drawn from these cases. The varieties of foreign bodies, in their relative frequency, was brought into consideration, and adduces that the likelihood of a fatal result when the case is left to nature is not so great when the offending body is a watermelon seed, or a grain of coffee, as in the case of a bean. Dr. Weist reaches the conclusion, from the facts presented in his statistics, that the surgical rule previously stated cannot be correct, and he sums up as follows:—

First. When the foreign body is lodged either in the throat, larynx, trachea, or bronchial tubes, emetics should not be employed, as they increase

the suffering and do not increase the chances of expulsion.

2d. Inversions of the body are dangerous, and should not be practiced unless an opening has been made in the windpipe.

3d. When symptoms of suffocation are imminent an operation should be resorted to at once; the same is true when dyspnœa is progressive.

4th. The presence of a foreign body in the air passages does not warrant an operation.

5th. While it excites no dangerous symptoms tracheotomy ought not to be performed.

6th. While a foreign body remains fixed in the trachea no operation should be performed.

With a few remarks on the performance of the operation the paper closed.

Dr. Geo. B. Walker, of Evansville, Ind., next read a paper on the subject of "Obstetrics." He said, in substance, that although midwifery had been practiced ever since the world begun, it had never been raised to the dignity of a science until physicians advocated "turning," and that since that time it had reached such a degree of perfection as to leave little to be desired. Yet, he said, the advantage of any maneuver to bring the head of the child into the strait is doubtful; with all the aid of science and skill the child's head can be better placed in position by nature herself. Of the value of bimanual manipulations, in comparison with the use of the forceps, Dr. Walker is thoroughly convinced. There are but few cases, indeed, he says, wherein turning is not admissible, and these are especially adapted to the use of the forceps. In the existing state of our knowledge of the forceps, it is believed that by the aid of turning the practice of obstetrics would not suffer much if they had not been introduced. He does not claim that the forceps could be safely dispensed with, nor that turning would be a sufficient and reliable substitute in all cases. But turning is the one operation that requires no instruments. The practitioner often meets with cases when no instrument is at hand, and when the delay occasioned by an effort to procure them would be dangerous. Even when the head has passed the superior strait it may be possible, in many cases, to replace it in the uterine cavity, and still deliver by turning. If this view be correct, it would limit the use of the forceps to those cases where the head is impacted and can be made to move in only one direction, and that toward the vulva. The short, straight forceps could then be made to answer every purpose. Leishman says the blades are more easily introduced, with reference to the child's head, when only one curve is to be considered, and if it be necessary to alter its position, this can only be effected by the short forceps. Dr. Thomas likewise yields his preference to them. Forceps delivery, notwithstanding its advantages, is not free from danger to the woman, but this danger is decreased by restricting their use to cases where the head lies near the perineum. Pelvic abscess, thrombosis of the vulva, are some of the consequences of their use. Midwifery would suffer but little, indeed, if the long forceps were entirely dispensed with. It has been argued that the blades of the forceps may be introduced through the cervix when the hand cannot be introduced. It seems a doubtful argument, and even if admitted, its propriety is doubtful. When the frequency of the use of the forceps at the present time is considered, it would seem that labor is hardly considered a physiological process. Too rapid as well as too tedious labors are not satisfactory. If it be necessary to terminate the pain of uterine contractions, anæsthetics should be preferred to the use of instruments. Labor ought to be left to the unaided powers of the woman, until some inability is apparent. When heat and dryness of the passage is observed it may be considered that some complication is about to occur; then the time for interference is at hand.

Some very intelligent physicians still adhere to the use of ergot. In the hands of those who know its uncertainties and its unreliability, it may yet sometimes be productive of good results.

As to the question of the power of the alkaloids of cinchonia to produce contractions, it appears to be still unsettled. There can scarcely be any objection urged against the gentle dilatation of the cervix to excite contractions; this is, indeed, in apparent imitation of nature's efforts to accomplish the same end. In reference to the management of the third stage, Dr. Walker observed, that in order to save time, no doubt the cord is recklessly drawn upon. Should it remain longer than thirty minutes, gentle traction and grasping of the uterus through the abdominal walls should be resorted to.

The injection of the uterine cavity by medicated solutions may be regarded as meddlesome midwifery. After considerable argument in reference to the treatment of placenta prævia, Dr. Walker arrives at the conclusion that Cazeaux's method of introducing the hand cannot be well improved upon. It is generally considered better to destroy the child by embryotomy, than to expose the woman to the mutilation and danger of abdominal section, but when the operation is made necessary, it should be so regulated, if possible, to save the life of both the mother and the child.

Dr. Jenks, of Chicago, next presented a paper upon "The Relations of Goitre to Pregnancy and the Generative Organs of Women."

The author having seen many cases of enlargement of the thyroid gland in young girls about the age of puberty, and which could be directly traced to disorders connected with the establishment of menstruation, was led to believe the subject worthy of study; his interest in the subject was increased by the large number of patients at his clinics exhibiting relations between goitre and uterine disorders. Dr. Jenks does not lose sight of the fact that goitre occurs in men, but gives tables of cases showing the relative frequency of the disease in the two sexes; he adds that the gland is of more importance in the female sex, that it is better developed and much more frequently affected by the abnormal enlargement under consideration. Dr. Jenks very curtly remarks, that while most authors make the geographical condition of the country responsible for the development of the disease, yet when it comes to be decided what those conditions are, the utmost diversity of opinion exists; some attributing it to the atmosphere, some to the altitude, and others to the character of the water.

Dr. Jenks apologized for the brevity of his paper, saying that his object in presenting it was more for the purpose of directing thought to the consideration of the subject than to establish a theory. When the honest object of Dr. Jenks, and the length of the papers presented by the majority of the readers was taken into consideration, his apology was gratefully accepted.

On Thursday morning the first paper to be presented was by Dr. David Prince, of Jacksonville, Ill., on "Dressing of Wounds." Dr. Prince made eight classes of wounds with reference to the mode of dressing. 1st, the slightest wound closed with simple plaster dressing. 2d, wounds closed by suture and dressed with dry earth, charcoal, etc. 3d, wounds closed by suture, followed by irrigation. 4th, wounds closed by suture, followed by immersion. These constitute the wounds dressed closed. 5th, open and dry. 6th, open with irrigation 7th, open with immersion. 8th, open, dressed with poultices.

The author then proceeded to the consideration of wounds by this classification, with reference to the treatment best adapted to each class. The first class of wounds, after the plaster is applied should be entirely covered with isinglass plaster and smeared with oil, one-tenth carbolic acid. Should inflammation beyond what is necessary to effect union occur, the further management should be by irrigation, immersion or poultices, securing a temperature in accordance with the comfort of the patient.

In reference to the sealing of wounds by the oozing blood, as advocated by Dr. C. B. Miller, in the Cincinnati *Lancet and Clinic* for Feb., 1880, the author remarked the practice as particularly adapted to wounds of the hairy scalp. No water should be applied, nor should the hair be cut nor shaved. In injuries of much severity it is safer to begin with irrigation. This suggestion is based upon the fact that sloughing is never devoid of the danger of septic poisoning.

While Dr. Prince regards the closure of the wound followed by irrigation with a carbolized or salicylized solution as good in its results he lends his support to the dry dressing; but better than either he regards the plan of immersion, the strength of the perpetual bath solution being not more than $\frac{8}{10000}$ for salicylic acid and $\frac{1}{1000}$ for carbolic acid. He regards cotton saturated with salicylic acid as an excellent dressing for the wound made in opening an abscess where the discharge of pus continues for some time. In those wounds which must heal by the granulating process, and which are so situated as not to admit of immersion, the plan of frequent irrigation (every twenty minutes) with the salicylic solution is warmly recommended. Dr. Prince says that under this plan a complete absence of the quality of sepsis is secured, and the wounded surface of the brain will granulate and cicatrize under it as perfectly as will any other structure.

Under the head of perpetual immersion Dr. Prince gave the details of a case in which the treatment extended over one hundred and twenty-two days; on the sixty-first day the first muscular slough separated, and on the one hundred and twelfth day the first dead skin came away. The margin of the sound skin had at no time exhibited undue redness. The case terminated in the most satisfactory manner, the boy having regained the use of his arm to such an extent as to fit him for a campaign drummer. Dr. Prince closed his paper with a recommendation of the plan of poultice dressing.

Dr. Wm. Dickinson, of St. Louis, read a paper on "Hemiopia—Mechanism of, Causation of; on the Theory of Total Decussation of Fibres of the Optic Tracts at the Chiasma."

Following Dr. Dickinson, Dr. C. H. Hughes, of St. Louis, read a paper on "Psychiatry." After speaking of the evils resulting from the want of better teaching on this subject, and of the appointment of superintendents and physicians to insane asylums by political preference, Dr. Hughes speaks of the excusable hesitation on the part of a conscientious physician to either withhold or issue the certificate of insanity that is to consign an individual to a State asylum. A great many reproaches have fallen upon the medical profession by reason of the voice which has retained too long a dangerous melancholic patient in the midst of a family, and fatal consequences have resulted to his friends. Many such examples might have been avoided by an intelligent answer to a few plain questions, such as "Is the patient so indecent in his habits and conduct as to render him unfit to remain longer at home?" "What antipathies has he for those by whom he is surrounded?" "Is there danger to wife, husband or child?" "Can the individual be treated and cured by medicine alone?" "How long would it be safe to attempt to treat a patient in the midst of the surroundings that may have engendered and excited the malady, and which may still contribute to keep it in existence?" Is the patient's insanity caused by any of the circumstances surrounding him, and if so, are they removable?" "Does the patient persistently refuse food, and is his condition in many or most respects such as to require the moral agencies, appliances, restraints, and constant surveillance which only a well regulated asylum or hospital can give?"

These are the questions which the physician must solve. How can the patient, if treated at home, be approached and treated daily without incurring his antipathy? When should home treatment cease, and the certificate be given which is to consign the patient to an asylum. Delay in most cases is dangerous. The exceptional cases may be somewhat easier determined by proper attention to the points just given. Much to aid in the solution of these questions properly may be gained by frequent visitations to institutions. Many forms of insanity resemble each other as much as those varieties of disease manifested in physical disease, and this resemblance is easily traceable in the early stages of mental disease, and therefore, their probable results and terminations may be very accurately arrived at by an acquaintance with the subject. Insanity then becomes preëminently a clinical study. On the subject of puerperal insanity, Dr. Hughes expressed the belief that the inadequate nutrition, the low diet sometimes ordered for women after parturition, when the nervous system cries most persistently for food, is responsible for many of the cases of hopelessly insane parturient patients.

He says, "I have never practiced the policy of abstemious diet in these cases, and never have I been called to see an example of mental aberration from the parturient state, but the first question I asked was in regard to the nutrition, and I have invariably found a nutritious though unstimulating diet have the happiest effects."

With regard to the insanity of gestation, judicious treatment may often keep it in abeyance until the crisis is past. In their treatment, especial watchfulness is necessary to protect the life of the child and mother. The asylum is often the only refuge for these cases. In regard to the paralysis of the insane, Dr. Hughes says, these patients being generally as happy in one place as another, and seldom dangerous wherever they are, may be treated as well at home, or if their circumstances admit of it, by traveling; it is not necessary to send them to an asylum. Acute psychic disturbances consequent upon hyperæmia, yield soon to rational treatment, though delusions of suspicion generally render them unfit to be treated at home. The advice which is calculated to keep these patients out of the asylum, should be carefully given, and should be based upon the disposition of the relatives and friends to keep a close and constant surveillance of the patient.

From the mild cases of melancholia are often developed the worst forms of insanity. While I am not willing, as some writers are, to say there is nothing difficult, obscure, nor mysterious, about diseases of the brain involving the mind, I am yet willing to place them on the same plane as diseases of other portions of the body. The moral management of the insane in institutions for their benefit is such as often to gradually lead patients slightly affected to abandon their delusions, by the contemplation of others whose insane absurdities they can easily comprehend.

When we look back through history, at the appalling devices for the punishment and imprisonment of the insane, does it seem strange that the rights of the insane should, in this day of progress, be contended for. Than our profession, none are more disposed to give them every right they should have. We think their liberties and rights can very justly be settled on the same principle that your right and mine is settled upon. Let every man be at liberty to do as he pleases, so long as what he does does not interfere with the peace and happiness of others." In the case of insanity, to secure that end, the individual may have to be subjected to some restraints; and so they be just, and not more than is necessary to secure the protection of an insane individual against himself or the lives and welfare of others with whom he may come in contact, no injustice can be said to be done. It is proper that an insane individual should have just that protection against himself that you and I would, in our rational moments, wish given us while in the delirium of typhoid fever. Their rights no doubt will be secured to them by an application, as is at present made of the principle involved in "Do unto others as you would that others should do unto you."

With the paper of Dr. Hughes the forenoon session of Thursday closed. In the afternoon papers were read by Dr. Williams, of Cincinnati, on "Amblyopia from Disuse;" by Dr. Porter, of St. Louis, on "Infantile Phthisis;" by Dr. Fairbrother, also of St. Louis, on "Mediæval Medicine;" by Dr. Archibald Dixon, of Henderson, Kentucky, on "Arrest of Evolution *vs.* Maternal Impressions;" by Dr. W. W. Seely, of Cincinnati, on "Non-astringent Caustic Treatment of Conjunctival Inflammations; and, on Friday morning, by Dr. Gustave Zinke, of Cincinnati, on "Quinine Inhalations in Diphtheria." Dr. A. M. Owen, of Evansville, was elected President for the ensuing year, and Dr. G. W. Burton, of Mitchell, Ind., re-elected Secretary. The next session is to be held at St. Louis. A vote of thanks was unanimously tendered the officials, the profession and the press of the city, for their kind treatment, and the Society adjourned.

Editorial Department.

Periscope.

A Successful Case of Nephro-Lithotomy.

At a recent meeting of the Clinical Society of London, Mr. Henry Morris recited a case:—

By the term "nephro-lithotomy" is meant the removal through a lumbar incision of a renal calculus from a kidney in which the pelvis is not dilated, and which, but for the presence of the stone, is presumably healthy. It is to be distinguished from the numerous cases in which the kidney is cut for the evacuation of fluid accumulated within it, whether as the result of a renal calculus, of tuberculous disease, or some other cause, and to which, from very ancient times, the name "nephrotomy" has been applied; as well as from those cases, also numerous, in which a stone has been removed after it has been detected through a sinus in the loin. The opinion of writers upon the subject has been universally adverse to the attempt to remove a stone from the kidney unless it could be reached through a distended pelvis, the chief reason urged being the danger of fatal hemorrhage if the existing substance of the organ was cut or torn. The case described in the paper conclusively proves the feasibility of the operation; and in answer to the question—is nephro-lithotomy feasible, and, if feasible, is it safe? the author stated "that it is entirely due to his friend and colleague, Dr. Coupland, who advised the patient to undergo the operation, that an affirmative answer can now, for the first time in the history of surgery, be given with certainty to this question." The position of the question before this case oc-

curred was reviewed; Marchetti's operation on the English Consul Hobson was referred to, and six cases in which the operation was planned, but in which it proved abortive, were mentioned. These six cases were considered encouraging because all the patients recovered from the operation of exposing the kidney, and, curiously enough, obtained, at least for a time, relief from their symptoms.

CASE.—Maria M., aged 19, a servant girl, of short, stout stature, and with a remarkably rough, scaly skin, had for eight years been subject, at times, to pain in her right side, accompanied, occasionally, with a feeling of sickness, and even actual vomiting. In September, 1878, these symptoms became more pronounced; her urine became dark-colored, and the pains so severe that she had to give up her situation and go under medical treatment. In April, 1879, she was admitted, under Dr. Thompson, into the Middlesex Hospital, and after treatment and rest, so far improved that she went back into service. A life of activity, however, brought back the old symptoms, and she was re-admitted (this time under Dr. Greenhow) into the hospital. In less than a month she was again able to go out, but only to return a third time, with urine as dark as porter, and with the pains in the right loin and groin as severe as ever. When she was admitted under Dr. Coupland, on December 29th, 1879, her urine was acid, and contained no other abnormal constituents than blood; there was some tenderness, but no swelling in the right loin. Again the urine cleared up, but the nephralgia was not relieved; consequently, on February 11th, chloroform was administered, and the right kidney exposed through an oblique lumbar incision. The right index finger was then passed over the posterior surface of the kidney, and at once detected something faintly projecting over the renal substance near the hilus. The renal substance was incised at this spot with a probe-ended bistoury, and a mulberry calculus, of triangular shape, and weighing thirty-one grains, was extracted by means of a scooping movement of the finger-tip. There was no hemorrhage at any stage of the operation. The upper end of the uterer was not dilated in the least, and as the stone could not be felt there, it was, consequently, not interfered with. No attempt was made to examine the front surface of the kidney. The wound was brought together with three sutures, and a drainage tube was introduced between two of them. The patient made a good recovery; urine ceased to flow through the wound on May 4th, and at the present time there is nothing whatever the matter with the patient, excepting that a sinus of 1¾ inches still remains in the loin, and discharges about a drachm of pus daily. *Remarks:* Thus the case shows that a calculus can be extracted from an *undilated kidney* by surgical operation without more risk than is amply warranted by the sufferings and general disability which the operation is designed to remove. But before the success of one case is allowed to influence treatment in others, four questions require consideration. 1st. Can the diagnosis as to the disease, and the organ affected, be made with certainty? 2d. What are the prospects of being able to complete the operation when a stone is found? 3d. What are the dangers of the operation? 4th. What is the best result which can be hoped for from the operation if successful? Mr. Morris, in answering each of these questions, gave arguments in favor of nephro-lithotomy, and finally expressed his agreement with Mr. Charles Bernard, the author of an account of Marchetti's operation described in the Philosophical Transactions of 1696, that many of the writers upon the subject of wounds of the kidney "ought not to have so magisterially exploded the operation," and hoped the operation would once again receive the consideration of the profession. (Med & Surg Reporter

The Elastic Bandage in Elephantiasis.

The following case was reported to the Clinical Society of London, in October, by Dr. S. MacKenzie:—

The patient, a male, aged 33, a native of Rosscar, county Fermanagh, Ireland, had never been out of Ireland till he came to England for treatment. He had worked always as a farm-laborer, and was healthy until his present disease. He never had syphilis, nor had eaten largely of fish. His home was about nine miles from the coast. Ten years ago he had an injury to his leg, which was much bruised and swollen. About three years after the accident the leg was noticed to be larger than its fellow; and from that time to his coming under observation the limb continued to enlarge. About four times a year, with a certain degree of regularity, the leg had become acutely worse. Preceded for a few days by nausea, headache, and shivering, the leg had become sore and painful, feeling extremely hot, looking red, and steaming. After continuing in this state for about a week, the surface of the leg began to discharge a fluid, clear, but of offensive smell. When the fluid escaped he gained ease; the heat left the leg, the nausea and constitutional disturbance subsided, and he returned to his usual condition; the limb, however, remaining of greater size than before the attack. The limb, when the patient was admitted into the London Hospital, in September, 1879, was enormously swollen, presenting several large lobulated masses of œdematous tissue, while the surface of the limb was covered by abrasions of the cuticle and papillary elevations. The right leg and scrotum were normal in all respects. There were no enlarged glands. No changes in the blood or urine were observed. He was confined to bed simply for the first month, with slight transient subsidence of the swelling. At the end of that time Martin's bandages were firmly applied to the leg, from the toes right up the thigh. He was kept in bed, with the exception of being allowed to go into the garden for one hour a day. The diminution in the size of the limb from the time the rubber bandages were applied was uninterrupted and very remarkable. All the lobulations subsided, the papillary elevations disappeared. A good deal of fluid exuded from the cuticular abrasions, and the decrease in the limb appeared to be proportionate to the fluid discharged As the swelling subsided, what appeared to be di

lated lymphatic vessels could be felt. The patient had no inconvenience from the treatment. During it, he had one paroxysmal attack, lasting a few days, in which his temperature rose to 103°, and the limb became hotter than its fellow. While the case probably differed in its origin from the tropical ones, and in the absence of filaria in the blood, the disease reached almost as high a grade as the elephant-leg of Barbadoes or India. The case was brought forward to show the good effects of elastic bandaging. There was no novelty in bandaging a limb in this condition, for this treatment was generally adopted alone or combined with other treatment in this disease; but there were not, to the author's knowledge, any published cases in which Martin's bandages have been used for this purpose.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Part xii of Drs. E. Klein and E. Noble Smith's "Atlas of Histology," published by J. B. Lippincott & Co., of Philadelphia, is now ready. It contains four admirably executed and beautifully colored plates, illustrating the microscopic structures of the skin, hair, and eye, together with full descriptions of the same.

OUR EXCHANGES.

Harper's Monthly, for December, opens with a charming "Christmas Carol," unique in style and arrangement, beautifully illustrated. It is followed by one of M. D. Conway's best descriptive articles of "Places and Their Notable People," "English Lakes and Their Genii," with added interest in the engravings of the gentle poets Wordsworth and Felicia Hemans, of whom this generation know so little.

Henry James, Jr., has finished "Washington Square," and it is succeeded by "Anne," a novel, by Constance Fenimore Woolson, that promises to be more than usually interesting. "The City of Pittsburg" is an exceedingly interesting sketch of our American Birmingham, with very fine illustrations.

Harper's Young People grows more interesting with every issue, and no more charming child's paper can be given to the little ones.

Scribner's Monthly, in its new dress, is very attractive, but as with new friends whom we may admire exceedingly, we miss the familiar face of the friend of years. The December number is excellent. "Hunting the Honey Bee" is charmingly illustrated. "Peter the Great" never flags in interest, much to Mr. Schuyler's credit. Among its very superior illustrations there are none more beautiful than the "Russian Girl in Ancient Russian Dress."

Littell's Living Age, a most regular and valued visitor, is always good. We could not do without it.

To all who may desire pleasant and invariably good family papers, we would recommend the *Agriculturist* as a *monthly* full of valuable information to the amateur farmer or the possessor of a small cottage garden. For *weekly* papers *Harper's Illustrated* is always attractive, the Germantown *Telegraph*, the *Vermont Journal*, the Cincinnati *Gazette*, and the Trenton *Gazette*, excellent; and for religious newspapers none are more valuable than the New York *Evangelist*, *Presbyterian Banner*, the *Presbyterian*, and *Christian Advocate*.

BOOK NOTICES.

Yellow-Fever; Its Origin and Prevention. By Robert P. S. Hargis, Pensacola, Florida. Published by D. G. Brinton, Philadelphia, Pa. Price $1.00.

It is many years since an earnest and fruitful discussion of this subject contributed much to the science of medicine. The most serious dissensions and fruitless conflicts have raged between physicians of different opinions and unequal tempers. The work before us, written with all the fervor of tropical blood, in a semi-tropical climate, may long be read as a logical defence of experience and direct observation as against the theories which serve but to sharpen our appetites for solid results. A hand-to hand encounter between an accomplished New Orleans Professor, Dr. Chaillé, the President of the Havana Commission of the National Board of Health, and the leading medical practitioner of a town like Pensacola, where yellow fever has proven so disastrous on healthy soil, cannot but excite the curiosity of the profession. It will do more, for it will increase the respect entertained for our Southern confréres, while shedding much light on quite a number of pathological questions.

Dr. Hargis was the first assailant in this fight. He took exceptions to a letter by Dr. L. Hardy, of Savannah, and in support of the National Board of Health advocated national measures of disease prevention. At the same time he expressed regret that the Havana Commission, appointed by the Board to investigate yellow fever in Havana, had, through its President, Dr. Chaillé, formed the notion of the endemicity of yellow fever in Cuba, and condemned the idea

of its naval origin in the tropical Atlantic. Since the ship Northampton, direct from Europe with emigrants, infected New Orleans, in 1853, Dr. Hargis has discarded the views entertained by his Professors in the Louisiana school, and as far back as 1858 declared that *no land* gave rise to the poison of yellow fever.

It is not to be regretted that Dr. Chaillé resented the strictures boldly made by Dr. Hargis. The result has been a protracted development of differences, in which the latter is most prolific, owing to the vastness of his experience and breadth of learning, and Dr. Chaillé is disposed to quote authorities and indulge in accusations of misrepresentation. Whatever may be the final verdict of the profession, it must admit that the Florida physician "hits hard," but "strikes fair." He is a most dangerous antagonist, since no amount of contempt or vituperation will draw him from his points and his subject. Demonstration, and *that alone*, is what he demands. While enforcing the truth that yellow fever never did originate spontaneously on this continent, he declares that it is impossible to class this disease with those due to specific forms of virus, alone developed in the bodies of the sick. The poison of yellow fever originates in man's environment, and not in man's body, within certain degrees of latitude, and only on the Atlantic Ocean, as forcibly indicated in Mr. Gamgee's work on "Yellow Fever a Nautical Disease." Professor Gamgee is quoted extensively, and his condensed history of the Plague is published in the form of a letter to Rear-Admiral Daniel Ammen.

With his authorities disposed of, as they have been most effectually by Dr. Hargis, we do not know what other line of action will be adopted by Dr. Chaillé. It is safe to say that no one can be satisfied with generalities on this question, and the invariable arrival of yellow fever to our ports in ships, points to national quarantine and international measures as the only means whereby to save the United States from periodic epidemics. With the admirable report on the Plymouth, we see recently noticed, the National Board of Health has an opportunity of gauging the value of Havana revelations and genuine American experience. Dr. Chaillé seems to be alone responsible for the chapters on the "Yellow Fever Poison" and on "Ship Origin," which have just appeared as portions of his final report, in the New Orleans *Medical and Surgical Journal*. His personal authority is not likely to outweigh the just criticisms of so very skillful a disputant and physician as Dr. Hargis, whose name will long be remembered as that of a bright writer and a solid controversialist.

The Brain as an Organ of the Mind. By C. Charlton Bastian, M.A., M.D., F.R.S., Professor of Pathological Anatomy and Clinical Medicine in the University College, London; Physician to University College Hospital and to the National Hospital for the Paralyzed and Epileptic. With one hundred and eighty-four illustrations. New York, D. Appleton & Co., 1, 3 and 5 Bond Street, 1880. Cloth, 8vo. pp. 708.

The author begins with a discussion of the uses and origin of a nervous system, together with its structure, and then proceeds to trace its development by successive steps from that of the lower forms of animal life to that of civilized man. In connection herewith he enters upon a study of the scope of the mind; reflex action and unconscious cognition; sensation, ideation and perception; consciousness in lower animals; instinct, its nature and origin; and nascent reason, emotion, imagination and volition. In the study of the human brain many interesting facts are brought forward, showing that there evidently is a gradual increase of the average cranial capacity, and consequently of brain weight, in the human race, under the influence of civilization, and that the higher the civilization the greater the difference between the male and female brain.

Another exceedingly interesting fact is the lack of symmetry between the two halves of the brain in the highly civilized as compared with that of the inferior races, where almost perfect regularity is found.

In the transition from brute to human intelligence, the influence of language cannot be overestimated, as thought in all its higher modes could not be carried on without its aid.

The internal structure of the human brain, and the functional relations of its principal parts are critically examined; Phrenology—old and new—forms the subject of one of the chapters, after which the will and voluntary movements receive the author's attention. The subject of cerebral mental substrata is next taken up, the volume closing with chapters on speaking, reading and writing as mental and physiological processes, the cerebral relations of speech and thought, and further problems in regard to the localization of the higher cerebral functions. Finally there is an appendix containing views concerning the existence and nature of a muscular sense.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

WHAT TO DO WHEN AT A LOSS.

Speaking of the recognition of the forms of disease, Dr. S. WEIR MITCHELL has used, in one of his gracefully written popular articles, the admirable simile that the faint indications of the nature of a malady are, at its outset, as if we saw only the first one or two letters of a word, and were seeking to read it all. These initials enable us only to classify it under some wide rubric, not to identify it; we wait hours or a day and other symptoms arise. We see other letters of the word, and as one after another is revealed the import and full meaning of the whole at length is disclosed.

But we cannot stand idly by and wait until our information is complete before we lend a helping hand. Something must be done at once; something useful, beneficial, at least, not harmful. Many a time does the physician find himself in this predicament. He sees the case early; he can form no diagnosis, but he is called upon to prescribe. Beginners especially find themselves at a loss on such occasions.

Some years ago Dr. ROBERT BARNES, of London, delivered a quaint lecture, in which he faced this difficulty. From his solid suggestions and from some other sources, we believe we can advance with confidence some general rules which will serve a good turn at a pinch. The first rule to be adopted is to—

Enjoin rest. This is a good rule; good for the patient and good for the physician. The Pharmacopœia contains no remedy of so much value and of such universal application. At the outset of many an acute complaint rest to the part and to the system is all that is demanded to insure recovery, safely, speedily and comfortably. It has also its advantages for the medical attendant. It gives him time to observe leisurely and to watch under favorable conditions the development of ulterior symptoms. It is obvious, however, that it is not enough to satisfy the expectations of the patient, no matter how much it satisfies all the requirements of the case. The Doctor is expected to *give something;* to administer some of the contents of those mysterious and attractive bottles and jars which adorn the shelves of his right-hand man, the apothecary. BARNES' rule is, here—

When in doubt, give salines. He wisely observes that there is hardly any disease in which salines will not do good in the beginning. What is not less important, there is hardly any disease in which they will do harm. They give favorable relief to general and local congestion, and they afford time for observation. Moreover, their variety is great, and their strength can be adjusted to the demands of the most delicate cases. The third rule may be to—

Relieve any organ functionally disturbed. This, however, requires to be admitted with some exceptions, and to be carried out with discretion. For example, it is not always wise to purge when the bowels are constipated. On the contrary, opium may be indicated, as in intussusception. The relief of the organ may often be brought about with better success by indirect measures. Thus, an engorged liver is most promptly relieved by stimulating the functions of the kidneys; and numerous examples of the kind will occur to every reader. The fourth rule is to—

Avoid committing yourself. As it is often impossible positively to know the complaint before you, it is equally essential neither to express a decided opinion nor to let it be seen that you have none. A mistake made at this moment on either side will be damaging. Those who boast that they can see through a disease at a glance are shallow people, and but one step above those quacks who advertise to tell the complaint without asking the patient a question. Nothing is lost, and often everything is gained, by *thoroughness.* The soundest physicians are those who proceed warily. The last and greatest as well as the oldest maxim to be observed is that which we owe to Father Hippocrates. It is to—

Do no harm. If none of the above precepts seem applicable to the case before you, at any rate take care that you do nothing to aggravate the condition of your patient. Recollect that there is at least a grain of truth in the satirical remark quoted by Mr. FRANCIS GALTON, in his "Art of Travel," to the effect that there is a great difference between a good physician and a bad one; but very much less between a good physician and none at all.

If an observance of the above does not carry the neophyte through the awkwardness of all his first visits, and spare to the more experienced an occasional attack of worriment, they will, at least in many instances, help him through a slough of doubt.

NOTES AND COMMENTS.

A Word of Interest to Every Subscriber.

Our new volume will appear not merely enlarged to the extent of eight pages in each number, but also on finely finished, toned paper, of superior quality. As such a material increase both in size and excellence of manufacture involves no small outlay, we would ask subscribers to be prompt in their renewals and to forward their subscriptions on or before the first of the year.

We trust all who now take the REPORTER will not only continue to do so, but will aid us in increasing its circulation. If any one of our present subscribers will remit the sum for a new subscriber along with his own subscription (in all ten dollars), *before the last day of January*, we will make him a present of either one of the following books, and send it to him by mail, postpaid:—

NAPHEYS. *Modern Medical Therapeutics*, cloth.
NAPHEYS. *Modern Surgical Therapeutics*, "
ATKINSON. *Therapeutics of Gynecology and Obstetrics*, cloth.
GOODELL. *Lessons in Gynecology*, cloth.
LANDOLT. *On Examination of the Eyes*, cloth.

We should be glad to have every present subscriber take advantage of this offer.

Accidents Apt to Occur During Aspiration of Pleuritic Effusions.

M. Potain, in a clinical lecture on this subject, (*Journal des Sci. Med. de Louvain*, October, 1880,) stated that he always used the aspirating apparatus bearing his name (same principle as those in use in the United States—exhaustion of air in flask, etc.) and that the accidents most frequently observed during the operation, were: 1. Puncturing a rib. When this happens, the trocar must be disengaged, its point slightly deviated, and again inserted. 2. Puncturing the lung; an accident occurring when there are adhesions by false membranes between the costal and visceral layers of the pleura. According to M. Charcot, the existence of such adhesions would cause sufficient increase of thoracic vibrations to enable the operator to diagnose such a condition by careful palpation.

Again, the lung is apt to be wounded when it is considerably congested and plunged in the pleuritic effusion. After this accident there is a slight effusion of blood; but pneumothorax does not often follow simple puncture of the lung, and the effusion in the pleura does not become purulent, as it does on the entrance of a very minute quantity of air from the exterior.

3. The diaphragm has been punctured, and the pericardial sac entered, when the diagnosis was not well founded; much more dangerous would be the wounding of an aneurismal enlargement of one of the thoracic vessels.

4. The intercostal artery is rarely wounded if the trocar has been inserted along the superior border of the rib. But when the trocar has been introduced, no liquid may appear, showing that either the lung has been penetrated or the point is imbedded in false membrane. This last accident is avoided by puncturing at the side, and not posteriorly, where these membranes generally accumulate. When air seems to enter the ap-

paratus, it is generally through some defective coupling, and the apparatus may be plunged under water, but the liquid flows slower from the pleura under such conditions.

Cough, sometimes violent, and often not easily arrested, occurs frequently during the operation, (in twenty-eight out of sixty-seven cases) and often it is not easily arrested when it occurs. The flow of the liquid should be arrested and intermissions made in its flow during the rest of the operation. This coughing is induced by the entrance of air into the bronchial tubes long unused to its contact. Perhaps in many cases it is due to the contact of the canula with lung in a state of congestion. The canula may then be slightly withdrawn when the coughing comes on.

Experiments with a Decapitated Head.

A notorious criminal was lately beheaded in Paris. About five hours after decapitation the body was removed to the School of Medicine for examination. The head was severed from the body by a clean cut, the knife having passed through the neck just below the vocal cords. The face was calm, and presented nothing particular. M. Dassy, preparator of anatomy, injected into the carotid artery some blood taken from a live dog. The face of the deceased became immediately flushed, and the lips reddened; and it was expected that some emotional movements of the muscles of the face would take place; but, owing to some misunderstanding, the body had not been given up till five hours after death, which, of course, interfered considerably with the experiments, and rendered the results incomplete. However, through the temporary apparent restoration of excitability in the decapitated head by the injection of warm and vivifying blood, M. Sappey, the professor of anatomy, was enabled to perform certain interesting experiments on the different muscles of the face by means of electric currents produced by Bunsen's battery.

On Hypophosphorous Acid.

This substance is well spoken of by Dr. J. Ashburton Thompson, in a letter to the *British Medical Journal*, Oct. 30th, 1880. He writes:—

Having tried the hypophosphite salts, I have now entirely relinquished them in favor of hypophosphorous acid. This acid, of which the dose is, I consider, one, two, or three drops for infants, five drops for adolescents, and ten drops for adults, given every four hours, I have by experience been brought to regard as a valuable means of treating all cases of disordered nutrition, whether the result of chronic or of acute febrile disease. It may be administered in a variety of combinations; and I have been led to prefer it to the alkaline salts because I have found its effects more promptly manifested, productive of more permanent results, and withal more generally useful. I regret that I am obliged to be content with making these assertions; observations which I was conducting with a view to publication having been unavoidably interrupted.

Handy Method of Resuscitating Neonati.

A correspondent of the *British Med. Journal* writes:—

I have been blessed about as many times as I have been cursed, for spending from one to two hours on my knees in front of a fire, with the only available means for inflating an apparently still-born child, viz.: a towel or pocket-handkerchief over the mouth, with compression of the nostrils with the thumb and finger, and as much pressure over the trachea as I thought would prevent the air which I blew from my mouth from entering into the stomach through the œsophagus. With all these precautions, I found that the air, after being used for so long a time, would enter the intestines, and even pass out at the anus, as well as inflating the lungs, and producing the desired effect. Still, it was very interesting to watch, first of all, a return of the heart's action; this becoming very rapid, then one inspiration occurring, and, after a few minutes, another; the action gradually increasing until the normal rate was arrived at, the cyanosis beginning to disappear after the first inspiration.

I am aware that there are numerous kinds of tubes used for this purpose, but very unlikely to be at hand when required; and I am sure a pocket-handkerchief and due pressure placed on the trachea will answer the purpose equally well, and be always available.

Pilocarpin in Diphtheria.

Last week fifty-two children died in Brooklyn, of diphtheria. Sad reports of similar mortality come from other quarters. It is our duty to call the especial attention of American physicians to the extraordinary success which is now reported in Germany, in this disease, from the *muriate of pilocarpin*. It is given in ordinary doses, internally, and a large number of cases have been reported by different physicians wherein the results were astonishingly good. As soon as the pilocarpin exercises its specific effect on the salivary glands, the false membrane detaches,

the inflammatory phenomena disappear, and improvement begins.

We particularly request our readers to try this treatment and report their results, whether good or bad.

Correspondence.

An Excusable Mistake.

Ed. Med. and Surg. Reporter:—

Often we can be taught by an inexcusable as well as an excusable mistake. I am disposed to accredit to myself the latter in the case I am about to relate, which has taught me the lesson, in the practice of medicine, to never take anything for granted, although general symptoms, previous history, condition, etc., seem to point to the correct diagnosis, and a conclusion is reached. As we continue in attendance on our case, and find it not yielding to remedies prescribed on which we had very good reasons for expecting a result satisfactory, from similar use in other like cases, we are forced to observe a little closer as to symptoms, etc., to do the work now which we should have done at our first, or at the furthest, our second visit; and what, too often, is the result? We find we have erred. Not so much from a first impression, perhaps; first impressions, to many, are astonishingly correct. Make use of this gift, if you have it, cultivate it, if you have it not, but never trust to it entirely; verify it by a close investigation, and too often you will find that you have not been led on by a clear first perception, but that your mind has been prejudiced by a previous attack simulating the present one, or that you have treated other patients for a disease, to all general appearances, of like character.

To the case in point. About one o'clock on the morning of the 18th of November I was called to see A. K., who, I was informed by the messenger, "was suffering from another attack of bleeding from the lungs," he having had two previous attacks—one about six months ago, and the other three months after. I found my patient spitting blood rather freely, handkerchiefs and towels showing evidence of his having discharged a good deal. I examined his pulse, found it weak and quick; he complained of pain, and a feeling of suffocation about the breast, and named other symptoms as in previous attacks. I made no further examination, believing I had a perfect knowledge of the case. (I would say here that he is of frail constitution, and without extraordinary care might at any time lapse into phthisis.) I ordered the remedies that acted so kindly on former occasions. Called the same morning about 10 A.M; the bleeding had ceased; I was asked by his father what I thought could have induced this attack. I replied, most likely the result of overwork or undue nervous excitement. His father told me that two days ago he had had a tooth extracted, and that he became very nervous from the operation, and was some hours recovering. The cause, in all probability, I replied (I was unconsciously correct as to its having to do with the extraction, as the sequel will show). I visited him on the 19th inst.; no further bleeding; directed him to resume his cod-liver oil, etc., and enjoined rest. About 10 A.M., 20th inst., was called hastily to him; found my patient bleeding more copiously than before; I was attracted by the peculiar manner he was ejecting the blood from his mouth, I know not by what else; I thought certainly this is not hæmoptysis. I then instituted an examination of the mouth, and to my utter surprise, gratification and chagrin, found blood coming from the cavity of the extracted bicuspid superior; by the use of tr. ferri persulph. and a pledget of lint I firmly plugged the cavity, and from then to the present writing there has been no hemorrhage, making it conclusive that this attack, from its inception, was one of bleeding from the cavity, as above stated. Two or three points for consideration, and I have done.

Two days after extraction, before bleeding set in, then an interval of two days, and a return of the hemorrhage. The chest symptoms he complained of can be more readily explained; he believed he had hæmoptysis, became very nervous in consequence, and in that condition it was no great stretch of imagination to feel all his old symptoms, all of which left when he was convinced it was not lung bleeding. I was told by the family that before this achievement they had a great admiration for my skill, but now it was supreme. Had they known my own estimate of their physician and become converts to my opinion of him, they would have added contempt after supreme. He was blanched from loss of blood; but so it goes—

> Praise and blame get strangely mixed up,
> Though retrospect shows 'tis fair—
> Proving they are equally fixed-up,
> And each doctor gets his share.

Philadelphia. H. C. P.

The Kneeling Posture in Parturition.

Ed. Med. and Surg. Reporter.

In the Reporter for November 27th, Dr. Blackwell contributes an interesting communication on "Methods of Managing Parturient Women and Puerperal Diseases." He particularly condemns a custom apparently prevalent among the women in many parts of New Jersey—that of remaining in the kneeling posture during "the working stage" of labor. This custom disgusted me considerably when I first observed it here some three years ago. It was contrary to previous experience, and all the teachings of the schools and the books, to have a parturient woman kneel on the floor in front of a chair or by the bedside, as the pains began to be severe, obliging the accoucheur to make a vaginal examination and deliver the child while she remained in that posture.

I had never heard, in Philadelphia, of such an irregular way of bringing an infant into the world. Prof. Penrose, at the University of Pennsylvania, had trained us most thoroughly in all that relates to the obstetric art, but his vividly personified model, Mrs. O'Flaherty, was always put decently to bed before the beginning of the second stage

of labor. The able lecturers at the Lying-in Charity, too, always assumed that the patient was to lie in bed after labor began in earnest. Here, on the other hand, the women often talked about being "put to bed" by Dr. So and so, and sometimes asked my "charge for putting a woman to bed;" yet, when the trying hour arrived, many of them insisted upon being allowed to keep out of bed till the work was all over.

However, I have become convinced of the peculiar efficiency, in many cases, of the kneeling posture. It may not be *secundum artem*, but it is *secundum naturam*, and may even be claimed to be scientific. When a woman lies on her side, the parturient forces must not only overcome the resistance offered by the rigidity and resiliency of the structures through which the fœtus must pass, but to some extent overcome also the force of gravity represented by the weight of the fœtus. When she is upon her knees, with her body nearly upright, this force of gravity directly assists the expulsive powers, acting thus as a *vis a fronte*.

Manifestly it may make quite a difference in the duration of labor, whether a twelve-pound child has to be partly lifted upward as well as forced outward, or brings its weight to bear as an auxiliary expulsive force. This seems rational and scientific, *a priori*, though such a view of the subject did not dawn upon me until after seeing a few labors conducted in this singular manner, and noticing how comparatively easy they were.

So impressed was I with the fitness of this position for patients sufficiently strong to maintain it, that I soon ceased objecting to it, and not only permit women now to kneel when they prefer to do so, but in the case of others, often advise the kneeling posture to be temporarily assumed, either on the bed or by its side, when the head is arrested by faulty presentation or failure to rotate. Often the change to this position has so modified the presentation, stimulated contractions and facilitated descent—then truly a descent—that the necessity of instrumental interference has been obviated.

Dr. Blackwell objects to this posture as less cleanly. It seems to me just the reverse. The women who adopt it usually wear a loose gown while kneeling, and keep a vessel underneath to catch all discharges. When the placenta comes, it is deposited in this same receptacle, and the new mother—her clothes having been changed—is placed in a perfectly clean and dry bed.

This is the programme as carried out in its entirety by many of the residents hereabouts, and I contend that much can be said in its favor, though in the case of my lady patients generally, I always follow the usual practice, only letting them get upon their knees temporarily when such a procedure promises to expedite a slowly-progressing labor.

After rigid enforcement of cleanliness and attention to all proper hygienic requirements, the best prophylaxis I have found against puerperal diseases is the use of vaginal injections of weak antiseptic lotions, such as the glycerole of carbolic acid, one or two teaspoonsfuls to the pint of warm water. Such injections, properly practiced —into the vagina merely, *not* into the uterus—are very grateful to the patients, and have, so far in my experience, proved protective against the more serious puerperal affections.

Atlantic City, N. J. BOARDMAN REED, M.D.

The Hard Rubber Pessaries.

ED. MED. AND SURG. REPORTER:—

I desire through your journal, to call the attention of members of the profession to the "Hard Rubber Uterine Supporter" manufactured by S. S. Staufer, of Philadelphia.

Of the various instruments given to the profession for the purpose, none have, in my hands, accomplished their object as comfortably and as well, and given as much general satisfaction as this one.

Every physician of any experience has had his ingenuity taxed, at times, to meet the requirements in a given case; he has, with the employment of ordinary tact, succeeded in elevating the uterus to its proper plane, but to support it there without injury or discomfort to the patient has always been the great desideratum.

Now, appliances depending upon the soft parts for auxiliary support fail in proportion to the degree of relaxation of the pelvic viscera, and as this relaxation is always present in a greater or less degree in prolapsus, it is irrational to expect to remedy a defect by augmenting its predisposing cause. The truth is that you have not only got to support the prolapsed organ, but its superincumbent parts as well, and the only point of direct support most available for the purpose is the pelvis itself.

The great objection raised against apparatuses for this purpose supported by belts fastened to the pelvis, is, that "every jar or shock received by the latter is communicated to the uterus direct, and therefore great danger exists that serious injury may result to that organ." This danger is, in my experience, completely obviated in Staufer's instrument, which consists of the usual belt around the waist with the elastic attachments of other instruments of its kind, but in addition to these there is a spiral wire spring within the stem supporting the cup, so nicely adjusted, in point of strength and resiliency to the elastic attachment tubes, that any shock received by the pelvis, is as effectually modified *at* the uterus as it would be were no apparatus worn at all. An examination of the instrument, or better, a trial of it, will convince any one that it is the nearest approach of a mechanical contrivance to the normal functions of the uterine ligaments yet devised. To secure comfort and entire satisfaction, all that is required is to select the proper size of cup: let it be just large enough to allow the cervix to rest easily therein—and here let me say, that the cups can be had of any size, from 1¼ inches, graded ¼ inch, up to 2½ inches across the top. These cups can be exchanged freely with the manufacturer, until a suitable one is procured, without extra cost to the purchaser. In fact, any of the hard rubber parts of this instrument are included in the exchange privilege, with only the nominal difference of cost in manufacture, a feature in itself,

aside from its great utility, that commends the instrument to the general practitioner.

I. N. GRUBB, M.D.

Thompsontown, Pa., Nov. 29th, 1880.

NEWS AND MISCELLANY.

The Jefferson Medical College.

The effort being made by the Faculty of the Jefferson Medical College to afford increased advantages of a practical nature to their students, merits the highest approval. While the trustees have not, as yet, fixed upon a graded course, and announced three years' attendance upon lectures as a requisite for final examination, nevertheless, much in the nature of reform is being done to give each student the maximum of useful knowledge. Besides the regular didactic lectures, several practical courses have been inaugurated from time to time, which are calculated to teach the students how to utilize the facts and principles discoursed upon in the lecture rooms.

Professor Rogers, assisted by Dr. Ward, continues his course in "Practical Chemistry" in the Chemical Laboratory. Professor Bartholow has instituted a course of instruction in "Pharmacy and Therapeutics." His assistants are Drs. Woodbury and McCollin. Professor Chapman has arranged to give laboratory instruction in "Physiology and Histology." In this department he is aided by Drs. Longstreth and Brubaker. Professor Da Costa has inaugurated a course for affording practical instruction in "Physical Diagnosis" to members of his clinical conference and to the third-term students. In the promotion of this work, he is ably assisted by Dr. Van Valzah, one of the physicians to the Jefferson Hospital, and also by Dr. Hughes, his chief of clinic. Dr. Wm. S. Little, as heretofore, gives to the members of the Graduating Class, practical instruction in Ophthalmology. Dr. Cohen, assisted by Dr. Barton, favors the same class in the study of Laryngology. Dr. Mears, assisted by Dr. Barr, has made arrangements for giving the students practical instruction in Gynecology.

For the first two courses mentioned above a small registration fee is charged, which amount is applied for the purchase of materials. The other courses are free to students coming up for graduation.

Every encouragement is held out to induce students to take a three years' course, and, as evinced above, laudable efforts are instituted to make every graduate a practical and efficient physician. "Let the good work go on!"

The Living Skeleton.

A man on exhibition as "the living skeleton" was lately brought before his class by Prof. A. B. Arnold, of Baltimore. The man is Isaac W. Sprague, and is now thirty-nine years old. He was born in Massachusetts, and was until twelve years old a healthy boy. The disease of muscular wasting then came on gradually, and after a few years he was compelled to leave the shoemaker's bench, where he was working with his father, and seek some other mode of earning his living. He engaged himself with showmen. When twenty-six years old he married, and has now three fine healthy boys. His height is five feet nine inches, and his weight forty-six pounds. The disease is progressive muscular atrophy. The accepted theory, and which Professor Arnold advanced, was that it was due to disease of the spinal cord. The present case, the lecturer explained, was a remarkable one, both for beginning so early and lasting so long, as the disease generally killed in five years, while this had lasted twenty-seven years. The length of life in the present case was due to the fact that the disease had not involved the muscles of respiration and deglutition, which were only now beginning to be affected. The head and face muscles were also in good condition, but the muscles of the body and extremities had disappeared. The subject still had a good appetite. The right side was not so much involved as the left.

Sexes, Nativities, and Races in Philadelphia.

The aggregate population of the city, by sex, nativity and color, is found to be as follows, in comparison with 1870:—

	In 1880.	In 1870.
Total population	846,980	674,022
Males	405,899	320,379
Females	441,081	353,643
Native	643,648	490,398
Foreign	204,332	183,624
White	815,182	651,854
Colored	31,798	22,168

In the colored population are included the following:—

	In 1880.	In 1870.
Chinese	80	12
Japanese	3	1
Indians	25	8

Yearly Revenues and Expenses of the Paris Board of Charity (Assistance Publique).

It is generally imagined, even in France, that this Board is possessed of large yearly revenues, and that the income from private donations was considerable, yet from such sources it amounts to but 1,199,300 francs yearly; from rent of buildings and from sums invested the annual revenue is 5,683,600 francs; from the impost on theatre tickets 2,771,000 francs; in fact the entire annual revenue amounts to about 15,633,000 francs; while the estimated expenses for 1881 will be 28,865,000 francs, leaving a deficit of 13,232,000 francs, to be voted by the Paris Municipal Council.

Personal.

—Owing to poor health, Dr. Charles R. Crandall has resigned his position as one of the resident physicians in the Jefferson Medical College Hospital.

—Dr. Carl Seiler, of this city, favorably known to the profession for his researches in laryngology, will spend some time this winter, beginning January 1st, at the St. James Hotel, Jacksonville, Florida. Physicians who have cases going to Florida requiring topical treatment of the larynx can refer them to Dr. Seiler with entire confidence that they will receive the best attention.

Items.

CORRECTION.—The address of the Maison de Santé, of Dr. Sajous, referred to on page 480, was incorrectly given—No. 351. It should be 315 Spruce street.

—Diphtheria is prevalent all through the West Branch Valley—Northumberland, Milton, Lewisburg and other towns being affected to an almost alarming extent. Many children and grown persons have died from it.

—The council having in charge the distribution of the London Hospital Sunday Fund has decided, in substance, not to make grants to hospitals in which religious liberty is not allowed, or in which religious principles of patients are tampered with.

—The Carthusian friars, having been exiled from France, are to make the famous Chartreuse liqueur in England. They possess the secret which imparts the peculiar flavor to their celebrated liqueur, and the secret discovered many generations ago has been regarded as a hereditary possession by the Order.

OBITUARY NOTICE.

Dr. Lucius N. Beardsley.

The death of Dr. Lucius N. Beardsley, November 22d, at West Haven, Conn., was the consummation of a life of notable usefulness. Dr. Beardsley practiced medicine in Milford, Conn. for forty-one years. His keen faculty of discriminating diseases, united to a remarkable tact and a fascinating address, made him a favorite no less in the community where he labored than throughout the County and State, where special deference was always paid to his judgment.

On several occasions Dr. Beardsley received the honors in the gift of the New Haven County Medical Society, and frequently was elected Delegate from the State to the National Medical Association. His services in the latter position were received with marked favor. His contributions to medical literature were very valuable as his range of observation was wide. To a singularly successful professional career he added the grace and the influence of a Christian gentleman.

—Dr. Lyman Mark Crane, died at Orange, N. J., in his seventieth year, on the 25th of November, after a brief illness. Dr. Crane had been a practitioner of medicine in Orange for about forty-five years, and for about the same period had been a regularly attending member of the Essex District Medical Society.

Dr. Crane graduated at Williams College, taking the degree of Bachelor of Arts. He then studied medicine, and was graduated from the New York College of Physicians and Surgeons, and licensed to practice by the New Jersey State Medical Society in 1836. He was a member of the Essex District Medical Society and of the Essex Medical Union.

—Among recent deaths is that of Dr. Alvan Bacon, of Biddeford, Maine. He was a thoroughly educated physician and had long enjoyed an extended practice. For many years he had been a leading citizen and a prominent member of the Congregational church. He was also distinguished for his zeal in the advocacy of the temperance cause and also against the tobacco habit.

—Dr. R. B. McCay, who died recently in Northumberland, Pa., was of Scotch extraction, and his father was the first male white child born at that place. The Doctor's grandson makes the fourth generation born on the same spot.

—Dr. Herman Row, an esteemed physician of Altoona, died on November 27th, after a long and severe illness caused by hemorrhage of the bowels. He was a graduate of the University of Pennsylvania, and leaves a wife and three children.

—In this city, November 30th, suddenly, F. D. Beck, M. D., aged twenty-nine years. Dr. Beck was a graduate of the Jefferson Medical College, and a gentleman of cultured mind. In his unexpected death the profession loses a promising member.

MARRIAGES.

BOUCHER—JUDD.—Thanksgiving Day, November 25th, 1880, in St. Marks Church, Brooklyn, Iowa. by the Rev. William Stevens, Perry, Bishop, of Iowa, F. H. Boucher, M.D., and Susie M. Judd, both of Brooklyn, Iowa.

CAMPBELL—CUTHELL.—At Mount Vernon, O., November 29th, by Rev. Charles Clearwater, Arch. M. Campbell, M.D., and Emma A. Cuthell.

DU BOIS—BLOIS.—On Wednesday, December 1st, at the Fifth Avenue Presbyterian Church, by Rev. John Hall, D.D., Henry A. Du Bois, Jr., M.D., of San Rafael, California, and Emma, daughter of the late Samuel Blois, M.D., of New York.

GARBER—SEALS.—November 10th, 1880, at the residence of the bride's parents, by Rev. W. E. Shaw, Dr. T. W. Garber, of De Witt, Iowa, and Miss Fannie Seals, of Monroe, Iowa.

TEAGARDEN—CROW.—At his residence, by Rev. A. Brown, October 26th, 1880, J. W. Teagarden, M.D. of Burnsville, Pa., and Miss Harriet N. Crow, of Crow's Mills, Pa.

WINCH—SYLVESTER.—In Northfield, Vt., Nov. 10th, by Rev. H. W. Worthell, Dr. J. H. Winch, and Ella M. Sylvester.

DEATHS.

BEARDSLEY.—At West Haven, Conn., November 22d, of pulmonary consumption, Dr. Lucius N. Beardsley, aged sixty-six years.

BECK.—In this city, suddenly, on November 30th, Dr. Theo. F. D. Beck.

GEDDES.—In Keene, N. H., November 8th, of heart disease, William Geddes, M.D., aged 46 years, 4 months.

MULLEN.—In this city, on Saturday, November 27th, Dr W. Walter Mullen, in the 40th year of his age.

PHELPS.—In Windsor, Vermont, November 26th, Dr. Edward E. Phelps, aged 77 years.

WOOD.—In Cincinnati, Ohio, Sunday, November 21st, Dr. Thos. Wood, in the 67th year of his age.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1242] PHILADELPHIA, DECEMBER 18, 1880. [Vol. XLIII.—No. 25.

Original Department.

Lecture.

EPIDEMIC CEREBRO-SPINAL MENINGITIS.

INTRODUCTORY REMARKS ON DISEASES OF THE SPINAL CORD.

BY FRANCIS DELAFIELD, M.D.,

Adjunct Professor of Pathology and Practical Medicine in the College of Physicians and Surgeons, New York.

Gentlemen:—We were speaking yesterday of epidemic cerebro-spinal meningitis, a disease which I told you is a general disease, but with certain characteristic lesions, these characteristic lesions being an acute inflammation of the membranes of the brain and of the spinal cord, especially of the pia mater of the brain and of the spinal cord. I told you that we have no very exact knowledge of the causation of this disease. We do not know how it begins. We do know, however, that it occurs in epidemics, and that in any place where there has once been an epidemic the disease becomes endemic for a number of years. We know, also, that some of these epidemics are very much more severe and fatal than others. We know that in some epidemics only children are attacked, while in other epidemics both children and adults are attacked. We know, also, that the disease is not contagious.

When we came to the symptoms of the disease, we found that in the most malignant epidemics there are some cases in which the disease runs a course of only a few hours. The patients are attacked suddenly, while apparently in perfect health, with a rigor; they at once become unconscious; the unconsciousness goes on into coma, and they remain comatose until they die. In the more ordinary cases than these, however, we find that the disease runs a longer course, but that there is considerable difference in different epidemics, as to the way in which the invasion of the disease takes place. And even in the same epidemic patients may be first attacked in somewhat different ways.

In the first place, as to the suddenness of the invasion. Some persons will be attacked very suddenly. Having previously been in perfectly good health they become sick very rapidly indeed, so that in the course of a few hours they will be sick enough to be in bed. In other cases, however, there is a period of several days during which the patients are good for nothing, are uncomfortable, and yet are not sick enough to be in bed, and after the lapse of these few days we find that the disease goes on in its regular course.

When the disease is fairly established, we find there are certain symptoms which we can expect to get in all or nearly all the cases. Of these symptoms, headache, I told you, is a very constant one indeed. Headache is present in nearly all cases, but it varies very much in its intensity in the different cases. Delirium is also present in very many cases, but this also differs both in its duration and in its severity, in its violence, in the different cases. There is also a difference as to the time when it is developed; in some patients the delirium coming on early in the disease; in other patients the delirium not coming on until after the disease has lasted several days. The intelligence may be very much changed, or it may remain nearly normal throughout the disease; but even if the intelligence continues normal the temper of the patients is changed. They are peevish, irritable, restless,

different from what they are when they are well. Convulsions are common enough in children, but are not very common in adults. Vomiting belongs to the beginning of the disease; belongs to the first few days of the disease. And in some cases it is so frequent, so annoying, that it may mask other symptoms which belong to the invasion of the disease. The bowels are usually constipated, but there are exceptional cases in which there is diarrhœa. If there is diarrhœa, it is more apt to occur near the close of the disease.

The patients suffer from pain and tenderness in the voluntary muscles, especially in the voluntary muscles of the back of the neck, and along the vertebral column. Less frequently there is some pain and tenderness in the voluntary muscles of other parts of the body. In the muscles of the back of the neck and along the vertebral column there is not only pain and tenderness, but there is sometimes, also, contraction. The muscles are contracted so that the head is drawn backward, and the body is drawn backward. The skin also may be unnaturally sensitive. There may be hyperæsthesia of the skin, so that the patients complain on being touched. The ears are often affected, the patients becoming deaf during the course of the disease, and in some cases deafness remaining permanent after their recovery from the disease.

The eyes are affected; the patients suffer from photophobia, from conjunctivitis, sometimes from suppurative inflammation of the cornea, sometimes from suppurative inflammation of the choroid coat of the eye. The conjunctivitis usually involves both eyes. The choroiditis or the keratitis may involve either one eye or both eyes. Besides this there is also often contraction of one of the internal recti muscles, so that there is strabismus. Eruptions in the skin, cutaneous eruptions, are present in some epidemics, and absent in others. The eruptions, when they do occur, are not always the same; the eruptions in the different epidemics have not always the same characters. In some epidemics they have the character of an erythema, in other epidemics the characters of a roseola, and in other epidemics there are petechial spots in the skin. The tongue is at first coated with a white fur, but remains moist.

If the patient does not at any time become very sick, it may remain moist throughout the whole disease. If, however, the case is a severe one, the tongue gradually becomes dry, and as it becomes dry it becomes brown, and may resemble very closely the tongue of typhoid or typhus fever. The pulse is usually full and not very rapid until the close of the disease. It does not usually run over a hundred until the last few days of the disease; that is, the last few days of the fatal cases of the disease. While the disease is coming on the pulse is often quite slow. It may be even slower than in health. A person who has naturally a pulse of seventy may have a pulse of only sixty or fifty while the disease is coming on. This rule, however, is not an absolute rule, it is a general rule. There are cases of cerebro-spinal meningitis in which the pulse is more rapid than this throughout the whole course of the disease.

The temperature is usually not very high, except in the bad cases. The height of the temperature varies in the different cases with the severity of the disease, generally speaking. The higher the temperature runs throughout the whole course of a case so much the worse is the case. But, in any given case, the temperature will vary from day to day, and these diurnal variations of the temperature do not mark the progress of the disease. The continuation of a tolerably high temperature, of one hundred and three or one hundred and four, with a pulse of sixty or seventy, is always very good reason for thinking that the patient is suffering from meningitis. The particular kind of meningitis is to be determined by other circumstances. But in epidemic cerebro-spinal meningitis, as well as in the other forms of meningitis, this rule holds good; that the continuation of a high temperature and a slow pulse is good reason for suspecting the existence of meningitis. If the disease lasts for more than ten days, or for more than two weeks, the patients are very apt to pass into a typhoid condition. The tongue becomes brown and dry, the delirium is constant, the patients may lie in bed quietly, except for the disturbance produced by the delirium; they may pass the urine and the fæces involuntarily; the cheeks may become flushed, and the patients will present an appearance which is not to be distinguished from that of patients suffering with typhoid fever. This condition does not usually develop until after the patients have been sick for ten days or two weeks. The duration of the disease in the malignant cases is only a few hours; in the more ordinary cases of the disease it varies between a week and three weeks. The more severe cases run the shortest course, terminating fatally. Of the cases which die, a very considerable number die at the end of the first or of the second week. Of the cases which get well, the disease is apt to be protracted over

two or three weeks. In those cases which are to get well, you sometimes have a sort of relapse. Not as well marked a relapse, not as characteristic a relapse as we get in typhoid fever, but still a pretty well marked relapse. At the end of, say two weeks, the patient may be apparently doing quite well; the temperature may have fallen to the normal, or nearly to the normal; the delirium may have disappeared; the intelligence may be clear enough; the patient's appetite may have returned. After continuing this way for two or three days, the symptoms will return. The temperature will run up again; the delirium will come back; the patient will lose his appetite, and he will be in very much the same condition that he was before. There may be several of these moderate relapses, and then finally convulsions will be fairly established.

The disease is attended, not infrequently, with certain complications. Bronchitis is found in a considerable number of patients; pneumonia occurs occasionally, not as frequently as bronchitis; pleurisy is also observed sometimes; pericarditis occurs not very frequently, and so does endocarditis, leaving behind a permanent lesion of the valves in some cases. Deafness, which occurs during the disease, may continue after the patients have apparently recovered. The blindness which may occur, if it be due to structural changes in the eye, will, of course, be a permanent blindness. In a certain number of cases the patients do not get well, but go on to suffer from a form of chronic hydrocephalus. The ventricles of the brain become dilated. The inflammation of the pia mater subsides, but the ventricles become dilated more and more with serum, and the patients go on to have the symptoms which I have already spoken to you of in speaking of chronic hydrocephalus. In some patients who recover there is permanent impairment of the mental faculties. The patients remain in a partially idiotic condition. The mental condition is not as good as it was before the occurrence of the disease. With this there may be loss of speech; there may be aphasia. This feebleness of mind and aphasia are not always permanent. They may continue some months after convalescence is fairly established, and then will gradually disappear. I have at the present time under my care a young girl in whom this condition of things was very well marked. She suffered from an attack of cerebro-spinal meningitis last winter, or rather early last spring—in March. After recovering from the attack of cerebro-spinal meningitis, she was left completely aphasic, and very feeble minded indeed. This condition lasted during April and May, with very little change. Then in June it gradually began to disappear. The aphasia disappeared first, then the mental faculties gradually began to improve, and continued to improve during the summer and fall, and now the intellect is as good as it ever was. This case, however, presented another complication which has remained permanent; that is endocarditis. She suffered from endocarditis at the time of the cerebro-spinal meningitis This endocarditis has left a lesion of the aortic valve which did not exist before she was taken sick. You will remember, then, that the prognosis of the mental condition and of the aphasia is not necessarily very bad. The patients may continue in this condition for some little time, and then may gradually return to the normal condition. In some cases, also, there is left behind paralysis of some of the voluntary muscles, paralysis either of one arm or of one leg, or of a group of muscles. This paralysis, also, is not always permanent. It may last for a certain length of time and then the patients will gradually regain the power of these muscles.

The prognosis of the disease varies very much with the particular epidemic. There are some epidemics of the disease in which the prognosis is bad; a large number of the cases die. There are other epidemics in which the prognosis is very much better; in which the larger number of the patients get well. Generally speaking, when an epidemic is subsiding, the scattering cases which occur afterward run a comparatively mild course. The cases of cerebro-spinal meningitis which we see in New York now do not run a very bad course. The larger number of them run a pretty mild course and get well.

Now, as to the treatment of the disease. In treating the disease you have to remember what its real characters are. That it is at the same time a general disease, and that this general disease is attended with a characteristic local inflammation, and that as a result of this you have patients suffering from symptoms dependent upon two different causes. They suffer from the symptoms due to the general poison of the disease, and they suffer from the symptoms due to the local inflammation which accompanies the disease. So far as the general poison of the disease is concerned, our treatment is not of any particular efficacy. We do not know how to act upon the poison of cerebro-spinal meningitis, any more than we know how to act upon the poison of typhoid fever, or of typhus fever, or of smallpox, or of any of that class of diseases.

For the local lesion, however, we can do something, and for the symptoms produced both by the local lesion and the general disease, we may also do something.

In the first place, for the local lesion. The indications for the local lesion are the same as they are for an acute meningitis of an epidemic or idiopathic kind. Thus, at the very commencement of the disease we may use local blood letting and cold. Local blood letting is only to be employed in persons who are strong and robust. You take the blood from the temples, or the nape of the neck, and from the upper part of the spine. You take the blood either by means of leeches or by wet cups. This, however, should only be done during the first three or four days of the disease. We should not do it after the fourth day of the disease. If you do not see the patient until after that time, there can be no object in local blood letting. Cold is applied to the head and to the back of the neck by means of ice-bags, and the application of cold is kept up pretty continuously. It should be kept up as continuously as possible for the first days of the disease; I think we may say for the first week of the disease, in a considerable number of cases. These two means, the use of blood letting and the use of cold, are the most efficient agents that we have for controlling the local inflammation. These agents, I say, are only efficient during the beginning of the disease, the blood letting during the first two or three days, the cold during the first week of the disease.

In addition to this local treatment, we have also to use measures to make the patient more comfortable. The symptoms which trouble the patient most are, usually, headache, restlessness and delirium. These symptoms are generally best quieted by the bromide of potash. The bromide of potash given alone, or with chloral, or with hyoscyamus, or with one of the preparations of musk, or with the tincture of castor. There are very few patients with whom the bromide cannot be used. There are very few patients who are not tolerant of the bromide. You give this in doses of twenty or thirty grains every three hours. The bromide will often be rendered more efficient if you combine with it one or other of the drugs of which I have spoken. The chloral hydrate is one of the best of these drugs. Unfortunately, there are some patients who cannot take chloral, in whom it produces unpleasant symptoms. In patients who can take it, usually ten grains is a sufficient dose to be given, combined with the bromide. In patients who cannot take chloral you will find the tincture of hyoscyamus often of very good service, and you give this in drachm doses with the bromide, making a mixture containing both the bromide and the tincture of hyoscyamus, so that the patient takes twenty grains of the bromide and a drachm of the tincture of hyoscyamus at each dose. Then, in patients, especially women, in whom the restlessness takes on the hysterical character, it has seemed to me that there is advantage in using the tincture of castor. You give this in the same doses as the tincture of hyoscyamus, that is, in drachm doses every three hours. You give it, then, in considerable amount. Occasionally we have to resort to opium. You find that neither the bromide nor the other drugs will answer the purpose, but, if possible, you use one or other of these rather than opium. Quinine is not, I think, indicated in this particular disease. Quinine is now given almost as a matter of routine for every disease from which patients suffer, but unless you give it as a matter of routine I think there is no particular advantage in giving it in cerebro-spinal meningitis. The temperature usually requires no particular attention. It does, indeed, sometimes run pretty high, but this is usually only toward the close of the disease, when there is no particular advantage in any treatment; but during the ordinary course of the disease the temperature is not apt to run over 104° in adults, and a temperature of 104° in adults is, in my opinion at least, a very harmless temperature. I think that adults bear a temperature of 104° for a considerable length of time without any danger whatever. If, however, you are disposed to attempt to lower the temperature, the best way to do this is by means either of cold effusions or of cold or tepid baths, or of the cold pack. Quinine has no effect whatever in reducing the temperature in this particular disease.

In children, cerebro-spinal meningitis runs a little different course from what it does in adults. The diagnosis is by no means as easy, especially if the children are quite young. The invasion of the disease is as a rule acute, and the invasion is very apt indeed to occur with convulsions. The patients have a number of convulsions, and these convulsions may be repeated at intervals during the first twelve, or twenty-four, or forty-eight hours, of the disease. Then the convulsions disappear, but the child continues dull, stupid, drowsy; you can hardly say, however, comatose, but it takes no notice, or very little notice of what is going on around. The temperature runs up pretty high from the very commencement of the disease. It runs higher than it does in adults.

The child will have a temperature of 104° by the end of the first twelve or twenty-four hours, and the temperature will continue between 104° and 106° or 107°, during the rest of the disease. In children, these may be the only symptoms that will present themselves to you. The occurrence of repeated convulsions, followed by a peculiar condition of stupor, and with this well-marked febrile movement. These, I say, may be the only symptoms that these children will present, and in this stupid condition, with well-marked febrile movement, the patients will continue until they die; or the stupor will gradually disappear, the febrile movement will gradually diminish, and the patient will get better. The disease, however, is much more fatal in these young children than it is in adults. And you will find a considerable number of these cases in young children in which it is impossible for you to tell whether the children are suffering from epidemic cerebro-spinal meningitis, or from acute idiopathic meningitis, or from acute meningitis secondary to suppurative inflammation of the ear, or tubercular meningitis. All these different forms of meningitis may give you symptoms which are exactly the same in these children.

The indications for treatment in children are the same as in adults, only in these young children you never think of local blood-letting.

We come now to the consideration of diseases of the spinal cord. If we make a transverse section of the spinal cord, we see at once that it consists of two parts, one of these parts we call the gray matter, the other the white matter of the cord. The gray matter is arranged in what are called horns, or cornua, and we speak of these according to their situation—of the anterior horns of gray matter, and the posterior horns of gray matter. The white matter of the cord is arranged in what are called columns, in columns beginning at the brain and running the whole length of the spinal cord, and of these columns, according to their position, we speak of the anterior column, the posterior column, and the lateral column. All these divisions of the cord it is particularly necessary for us to remember. That is, that the cord is composed of gray and white matter, that the gray matter is arranged in horns, or cornua, of which we distinguish the anterior and posterior, and that the white matter is arranged in columns, of which we distinguish the anterior, the posterior, and the lateral columns. And, as you know, of course, we have the anterior nerve root connected with the anterior gray cornua, and the posterior nerve root connected with the posterior gray cornua.

There are some points in the physiology of the spinal cord which it is necessary to have in our minds when we come to the consideration of the diseases of the cord. We know that impressions which are received by the sensitive nerves of the body, by the peripheral sensitive nerves, are carried to the posterior roots. From the posterior roots to the posterior gray cornua, and from these to the posterior and lateral white columns, thence to the brain. Sensitive impressions pass first, I repeat, to the posterior nerve roots, then to the posterior gray cornua, from the posterior gray cornua to the posterior and lateral white columns up to the brain. The posterior white columns are the channels for the sensations of touch, or pressure, and of temperature. The sensations which we designate by the names of touch, or pressure, and of temperature are carried by the posterior white columns to the brain. But the sensations of pain, as distinguished from the sensations of touch, pressure and temperature, are probably transmitted to the brain through the gray matter of the cord. It is not absolutely certain, but it is exceedingly probable that we can distinguish these two channels by which the different sensations of touch, pressure, temperature and pain are conveyed from the periphery of the body to the brain. The lateral, and perhaps also the anterior columns of the spinal cord, transmit voluntary motor impulses from the brain to the anterior cornua. The anterior cornua of the gray matter have the power of regulating the voluntary muscles. They regulate the impulses which are transmitted from the brain to the voluntary muscles. The centres for the coördination of the different voluntary muscles are probably situated in the brain, and the impulses from these centres of coördination are transmitted through the posterior white columns. What is called reflex motion as distinguished from voluntary motion is produced by the gray matter of the cord. But these reflex motions are normally controlled by the brain. If the influence of the brain is taken away then these reflex motions which belong to the spinal cord will no longer be controlled. They will become exaggerated. These are the points which it is necessary for us to remember in thinking of diseases of the spinal cord.

Now, there are also some general symptoms belonging to a number of different diseases of the spinal cord, which we also have to remember. You may think this a little hard, gentlemen, but it is important if it is hard. Of these general symptoms we know, in the first place,

that disturbances of sensation are due to lesions of the gray matter of the cord and of the posterior columns. If a person has any disturbance of sensation, that is any disturbance as to his sensitiveness to heat, to cold, to pressure, to tactile sensation, to pain, we know that there must be some lesion either of the gray matter of the cord, or of the posterior white columns of the cord, or of both these. Some persons will tell you that their skin feels too cold, others that the skin feels too hot, others that they have a feeling of numbness of the skin, others that they have a feeling of pricking or of formication in the skin. We do not know to what part of the spinal cord these unnatural sensations are to be referred. It is important to remember that these peculiar sensations, which are very common indeed, are as yet not to be definitely located in any particular part of the spinal cord. If the patients suffer from well marked neuralgic pains, these neuralgic pains are due, so far as we know, to changes in the posterior nerve roots, to the nerve roots which are given off from the posterior gray cornua. Our knowledge on this subject, however, is not exact, we can only say that, so far as we know, neuralgic pains connected with spinal cord diseases are due to changes in the posterior nerve roots, rather than to any change in the cord itself. The generalized pains from which some patients suffer—not neuralgic pains, but general pains in different parts of the body—these again belong to the class of uncertain symptoms. We do not know what particular part of the cord it is which, when it is diseased, gives rise to these generalized pains.

Paralysis of the voluntary muscles, when it is rapidly followed by atrophy of the muscles, is due to disease of the anterior horns of the gray matter, or to disease of the anterior nerve roots. If paralysis of the voluntary muscles is accompanied with permanent contraction, and there is no atrophy of the muscles, then we can usually infer that the lateral columns of the cord are the seat of the lesion. If there is first loss of voluntary motion, then permanent contraction of these paralyzed muscles and at the same time marked atrophy of the muscles, then we may infer that the lateral white columns of the cord are diseased. If the patients suffer from tremor of the voluntary muscles, from a peculiar agitating movement of the voluntary muscles, as we see in certain cases of paralysis agitans, as it is sometimes called, this is due, as a rule, to what is called multiple sclerosis. That is, to a number of different foci of lesions in the spinal cord. There may be at the same time similar foci of the lesion in the brain. If the patients suffer from diminished reflex action it is usually due to disease either of the anterior nerve roots, or the posterior nerve roots, or the gray matter of the cord. If there is exaggerated reflex action, instead of diminished reflex action, it is due to some lesion which interrupts the natural channels of communication from the brain to the cord. If, for example, a patient fall from a height, and dislocate one of the cervical or one of the dorsal vertebræ, so that the cord is completely compressed, you will find that this patient will have exaggerated reflex action of those parts of the body below the seat of the injury. The controlling power of the brain being shut off by such a lesion of the cord, the reflex action of the cord becomes exaggerated. We see the same thing in many transverse lesions of the spinal cord. Any lesion which destroys or which renders useless a certain part of the spinal cord will be liable to produce increased reflex action of those muscles which are supplied by nerves coming off from the spinal cord below the seat of the injury. At our next lecture we will take up the subject of myelitis.

Communications.

CHRONIC INTERSTITIAL NEPHRITIS.

A Case Reported to the Northern Medical Society of Philadelphia,

BY J. G. HEILMAN, M.D.

G. W. R., aged 53 years, salesman in a wholesale dry goods house, of regular habits and good family history. Had several attacks of acute articular rheumatism previous to coming under my observation, but there do not seem to have been any cardiac complications; at least, the heart, when he came under my care, was normal in size and free from murmurs. For years his skin has been pale, and he complained of weakness after even moderate exertion. As he was a near neighbor he was seen almost daily during the past six years, but aside from the fact that he was not very strong. my attention was not called to any thing special in his condition until Aug. 5th of the present year (1880).

At this time he had a severe attack of cholera morbus, attended with severe cramps in the calves of the legs. The attack had lasted eight hours when I saw him, and he was very greatly prostrated. A hypodermic injection of half a grain of sulphate of morphia gave almost immediate relief. He went to sleep twenty minutes after the injection had been given, and rested com-

fortably all night. The next morning he was doing so well that nothing further than ordering tonic treatment was deemed necessary. He gained strength very slowly, however, and on the 22d of August, sixteen days later, he again consulted me. I found him suffering from a moderately severe attack of remittent fever, which yielded to treatment in about a week's time. Dr. Charles N. Cook, owing to my absence from the city, saw him during a portion of this time, and confirmed the diagnosis. After leaving his bed he complained of great weakness, and restlessness at night, with some headache. His appetite was not as good as usual during convalescence from an acute disease. Tonics, consisting of quinine, iron and strychnia, were freely given, but without any apparent effect. He remained in very much the same condition, gaining strength a little, until September 16th, when he walked out. During the walk his strength gave out completely, and although he walked less than three blocks it was only with the utmost exertion that he succeeded in reaching his home. His debility now became greater, and his headache and restlessness were very much aggravated. During the progress of the disease frequent inquiries were made concerning his urine, but he had observed nothing abnormal either as to frequency of voiding, color, or quantity. I now obtained a specimen, and on examination found it to be about half albumen. My friend, Dr. F. S. Isett, kindly submitted it to a microscopic examination, and found granular casts and oil globules. The patient now, for the first time, admitted that his eyesight had been gradually failing for a year past, and that especially rapid had such failure been during the past six months.

Dr. D. M. Barr saw the case several times with me, in consultation, but in spite of all treatment it progressed rapidly to a fatal termination.

Twitchings of the muscles of the hands and legs and of the face appeared and continued throughout, though no general convulsions occurred. He was delirious most of the time, seldom recognizing the members of his family. The treatment consisted of tonics, iron, quinine and strychnia, digitalis, ergot and tincture of cantharides.

The amount of albumen diminished under this treatment to one fourth. When uræmic symptoms became marked the compound powder of jalap was administered, in fifteen grain doses every two hours, with temporary relief. The restlessness was relieved with chloral hydrate and morphia, in doses of one-eighth of a grain. Cupping over the region of the kidneys gave considerable relief. The action of the heart was feeble, but no murmurs could be detected at any time. Death took place September 23d.

Several facts connected with the case are worthy of note. The common belief that opiates are badly borne in Bright's disease is not supported by the history of this case. The dose of one half grain given hypodermically, before the existence of kidney disease was suspected, had a most happy effect, and the dose of an eighth of a grain was frequently repeated up to the day of his death, without exerting the slightest injurious effect; indeed, he always seemed stronger after a sleep produced in this manner.

The effect of severe exertion in aggravating the symptoms was well illustrated by this case. The disease had undoubtedly existed for not less than two years, but at the beginning of the present year, a portion of work much more laborious was assigned to him, and at once his eyesight commenced to fail more rapidly, his headaches became more frequent, and his debility more marked. The very rapid progress of the disease after the severe exertion of the walk while convalescing from remittent fever illustrates the same fact.

The entire absence of dropsy, even with the urine one-half albumen, is another fact worthy of notice. This, together with absence of other symptoms pointing to the kidneys as the seat of disease, explains why the diagnosis was not sooner made. It must be remembered that the disturbance of vision and the frequent headaches were not complained of, or their existence even admitted, until after the albumen had been found in the urine. The pulse and temperature were almost normal until a few days before death, when the pulse gradually became more frequent and feeble. They showed the usual changes while suffering from remittent fever.

An autopsy was made fifty-six hours after death, but only the cavity of the abdomen was opened. All the organs with the exception of the kidneys, were found normal. The right kidney showed more disease than the left, and was presented to the chairman of our committee on morbid specimens who will make a report of its pathological condition.

REPORT OF COMMITTEE.

The kidney presented by Dr. Heilman appears externally of nearly the normal size. It has a large collection of fat about and within the pelvis, infiltrating the lower part of the cones to such an extent that the lower third appeared to be

made chiefly of fat. The capsule is not abnormally adherent. Upon section, the cortical portion appears much diminished in thickness, about half the usual width. A thin section under the microscope shows an increase of the connective tissue, which is more marked about the Malpighian bodies and blood vessels. The tubules are in places filled with hyaline matter, some of which encloses detached epithelial cells, *i.e.* hyaline and granular casts, *in situ*. The specimen is, therefore, one of red, granular contracted kidney of the older authors, or chronic interstitial nephritis of more modern nomenclature.

Two distinct pathological conditions have long been recognized as being the result of chronic Brights' Disease; the large white kidney and the red contracted kidney; and the question has often been asked, do these represent different stages of the disease, or two distinct diseases?

The weight of pathological evidence, to-day, seems to be on the side of their being two distinct pathological processes *ab initio*, one beginning in the connective tissue about the blood vessels, the other in the renal tubules.

If this be true, there ought to be a distinct clinical history and line of treatment appropriate to each.

The complete history of the present case is, therefore, a step forward toward the settling of this vexed question.

The specimen was exhibited with a section under the microscope.

DIPHTHERITIC CROUP.

BY J. M. BATTEN, M.D.,
Of Pittsburg, Pa.

Pseudo-membranous, membranous or diphtheritic croup has been, from time immemorial, considered a very grave and fatal disease. It is my opinion that the two diseases, membranous and diphtheritic croup, are distinct diseases, and require, in many cases, distinct treatment. It is possible to confound the one disease with the other; for, on account of the great fatality of the diseases, we are not often offered an opportunity of studying their sequelæ.

Diphtheritic croup is a constitutional disease with local symptoms and sequelæ of albuminuria, paralysis, debility, and perhaps heart paralysis. Membranous croup is a hyper-fibrination of the blood; children teething, with a large amount of fibrine in the blood, are likely to be attacked with membranous croup; besides, the latter disease has no sequelæ. I will not, however, stop to discuss the pathology of the disease, but will pass on to give you the history and treatment of a case of diphtheritic croup.

The case I am about to relate is a good type of the disease, and presented all the symptoms which might indicate a fatal termination.

I saw James H. W., aged 6 years, on November 2d, 1880. He had been sick about a week, with what the mother stated was a bad cold. Upon examination, the throat was red, with a patch of membrane behind each tonsil; the tonsils were not very much enlarged, the sub-maxillary glands were slightly enlarged, the tongue was coated, the breathing was labored and abdominal; there was aphonia; the cough was dry and had a ringing, whistling sound; the patient had been restless the previous night. I immediately imparted my opinion to the family that the case would likely terminate fatally. I put the child on No. 1:—

℞.	Bromid. potass.,	gr. l	
	Chlorat. potass.,	gr. l	
	Tinct. aconiti rad.,	gtt. xij	
	Syr. tolutani,		
	Syr. senegæ,	āā	℥ ij
	Aquæ,	℥ iss.	M.

Sig.—A teaspoonful every three hours.

The following day the symptoms, if anything, were more grave; the child had perspired freely after having been placed in bed, in a warm, comfortable room. The eyes were glassy and ejected, breathing difficult, head thrown back. Countenance anxious, pulse 110 to 120. Respirations frequent: a dry mucous râle in both bronchia. The case was not one favorable for tracheotomy, for the membrane ramified the trachea and bronchia and bronchial tubes of both the lungs. I continued the treatment till evening, with the addition of inhalation of lime steam, or steam from lime, when I put the patient upon No. 2:—

℞.	Chloratis potass.,	gr. lxxx	
	Tinct. ferri chlor.,	gtt. clx	
	Syr. simplicis,	℥ ss	
	Aquæ,	℥ iss.	M.

Sig.—A tablespoonful every three hours.

and withdrew the first prescription.

I kept the patient on this until Friday morning, November 5th, with inhalation of steam from lime. There was no improvement; the father stated to me that the patient could not swallow the medicine during the previous night. I then put him on No. 3:—

℞.	Hydrarg. chlor. mit.,	gr. iv	
	Pulv. ipecac.,	gr. ij	
	Albi sacch.,	gr. xx.	M.
	Ft. chart. viij.		

Sig.—One powder every three hours.

I told the father to give the second prescription as often as possible.

In the afternoon the patient commenced expectorating a thick, tenacious, muco-purulent matter, a half pint in quantity; after this the patient commenced to breathe easily, the cough became loose, expectoration easy, and he went to sleep for the first time since the night of November 1st (Monday night). The patient is now rapidly convalescing; has not regained his voice. During the little patient's sickness I gave whisky and nourishing diet freely. On examining the urine, November 7th, I found it loaded with albumen.

I continued the treatment with prescriptions No. 2 and No. 3, until November 8th, when I dropped the No. 3, the calomel, and continued No. 2, tinct. chlor. of iron, etc.

Now, the question may be asked was it prescription No. 2 or No. 3 that benefited the patient. I believe it was prescription No. 2, together with the inhalation of steam from lime; but the calomel, if it did no good did no harm, and took the place of prescription No. 2 when the child could not swallow. Now, this was an interesting case, and is the fifth patient with this disease, diphtheritic croup, I have seen, all of which died except the latter; and if no sequelæ should arise to endanger his life, I think my patient will convalesce rapidly. Throughout the disease my little patient was very restless, gasping for breath, and wanted to be fanned.

Hospital Reports.

PENNSYLVANIA HOSPITAL.

SERVICE OF DR. THOS. G. MORTON.

REPORTED BY GEO. F. SOUWERS, M.D.

Case of Traumatic Tetanus, Recovery.

GENTLEMEN:—I present to you this morning a rather rare, not to say a curious case. Tetanus is at any time an interesting disease to consider, as much from its comparative rarity as from the peculiar phenomena presented and the unsatisfactory, and not unfrequently from the opposite forms of treatment. The boy who is before you is thirteen years of age; was knocked down by a slowly moving train of cars; in some way unexplained, instead of being run over by the wheels he was thrown up on the axle, and dragged in this position. On being admitted to the hospital (on the 22d of September, 1880), he presented the following injuries; the scalp covering the occipital bone was entirely torn away, and hung down upon the neck; the skull was entirely denuded of its pericranium, and was also much roughened from the sand and slag on the railroad bed, which was literally ground into it and into the torn tissues. There must also have been a squeezing force, as the left clavicle was fractured at its middle, and the second, third, fourth, and fifth ribs of the left side had started from their articulations with the sternum; some few of the ribs on the right side had also been fractured; the right shoulder and the body presented formidable contusions. There was profound shock, and reaction came on slowly after the use of stimulants, and hot beef tea, and rest. To reduce the fracture of the clavicle, the patient was placed on his back and the arm placed across the chest and bandaged. To the scalp injuries a dressing of carbolized lint was applied, after being thoroughly washed with carbolized water, in order to remove, as far as possible, the debris, etc., the result of the accident. Up to the 24th the system responded but slowly to treatment; at first it seemed as if the long scalp flap would slough, but at this date, while there has been a great deal of suppuration there has been no sloughing. No tension whatever had been made to keep the flap in position. On the 23d ultimo he commenced with symptoms of trismus, which rapidly developed; marked opisthotonos finally made its appearance. The whole muscular system was implicated at this time, and morphia was employed hypodermically, and conia in one-fourth drop doses, gradually increased to one-half drop, was given every two hours. Under this treatment he gradually but very slowly improved, until now he is able to be out of bed. There remains, however, some slight irritation of the neck and facial muscles, which prevent the patient's turning the head freely; in fact, the head is more or less rigidly fixed, and turned slightly to the right, for which symptom he is now receiving large doses of the bromides, coupled with a tonic course of treatment. I bring the case before you, gentlemen, to show you the good results which I have seen from conia, which has proved in my hands very satisfactory. Recovery, under the most favorable circumstances, is rare in the adult, while in youthful subjects trismus and death are almost synonymous terms.

In this case, subsequently, a large portion of the superficial table of the occipital bone was removed by Dr. Morton; the granulations underneath were exceedingly florid and healthy—and at this date, December 1st, the boy is sufficiently well to be able to leave the hospital.

Medical Societies.

CLINICAL SOCIETY OF MARYLAND.

Meeting held November 19, 1880, THOMAS S. LATIMER, M.D., President, in the chair.

Reported by EUGENE F. CORDELL, M.D.

Polypoid Tumor from the Neck.

Dr. Michael exhibited a small tumor, about the size of an acorn, removed from the neck of a boy aged 8 years. The history showed that the patient had a wart upon the neck, and that his parents, with a view to getting rid of this, had tied a string tightly around its base. The result was that it grew to the size above mentioned, presenting the appearance of a mucous polypus attached to the surface by a pedicle. Dr. Michael

clipped it off with scissors. The hemorrhage was insignificant. At his request it was referred to the Committee on Morbid Growths.

Diabetic Urine Remaining Unchanged for Several Months.

Dr. McKew exhibited a specimen of urine obtained last May, from a patient suffering from diabetes, which, although kept upon his desk for six months, and frequently exposed to the air, showed no signs of decomposition, but was still clear and without unpleasant odor. It was obtained shortly before the death of the patient, whom he had only seen in consultation. The specific gravity was 1.025, reaction acid. On passing it through filtering paper a very slight sediment was obtained, which had not yet been examined. He was entirely at a loss for an explanation of the remarkable preservation of the specimen, unless it were possible for the salicylic acid, which the attending physician had been administering, to have had something to do with it. In answer to a suggestion that alcoholic fermentation may have occurred to some extent, Dr. M. said this was negatived by the fact that the specific gravity had remained unchanged. The quantity of the specimen was too small to admit of examination for alcohol.

Benzoate of Sodium in Hooping Cough.

Dr. J. Shelton Hill had tested this remedy in several cases, one being his own child, aged 3 years. There was no diminution of the frequency of the paroxysms, and their intensity was little, if any, lessened. It promptly checked the vomiting, however, which in one case was incessant, everything taken in the food being immediately ejected and nutrition being seriously impaired in consequence. The dose employed in the child of three was ten grains every three hours.

Some of the Errors in the Diagnosis of Eye Diseases into which General Practitioners are most Apt to Fall.

Dr. Theobald began his paper by remarking that it is not surprising that general practitioners make mistakes, since they make no use of some of the essential means of diagnosis. Oculists would meet with the same fate if deprived of their ophthalmoscopes, test-types, etc.

The importance of a correct diagnosis was illustrated by a reference to glacuoma and iritis, which, if improperly understood and treated at first, produce irremediable effects. Two cases of glaucoma, mistaken for cataract by the family physician, have come under his observation, in which delay was advised, and the sight, in consequence, lost. Glaucoma is often difficult to recognize in its incipiency, but when fully developed this becomes easy. Reliance must be placed upon increased hardness of the balls, which can be determined by a comparison with the physician's own eye or with the healthy eye of the patient. Require the patient to look down during the examination. Any increased tension should cause at once a resort to the ophthalmoscope. Iritis is liable to be mistaken for conjunctivitis, and treated with astringents, when atropia should be employed.

The books are, in a measure, to blame for this, because of the undue importance which they attach to the difference in the character of the injection of the eye in these two affections, as a distinguishing feature. Pain and photophobia, especially in adults, suggest iritis in these cases. The mobility of the pupil is an important feature, and should be examined into. In conjunctivitis this is in no wise impaired. Should the question of mobility be in doubt, atropia should be resorted to (gr. j–℥j, ordinarily a sufficient strength), which will establish the diagnosis beyond a doubt. The use of *oblique illumination* is equally conclusive, and every physician should be familiar with this simple method of examination. The requisites are very simple—a dark room, a bi convex lens, and a gas or lamp light. We may thus examine the structures of the ball back to the anterior layers of the lens; this method is also applicable in examining for foreign bodies, ulcers of cornea, etc. Myopia, hypermetropia and astigmatism present great difficulties to the general practitioner. Cases of chronic blepharitis, conjunctivitis, headache, etc., often depend upon these abnormalities, and can only be relieved by the use of suitable glasses; we should bear in mind the possibility of such a relation, and resort to glasses if we have any reason to suspect its existence.

Foreign bodies are often overlooked. In a case of foreign body which had been lodging in the cornea for several days, the attending physician had seriously contemplated the use of mercury. In another case, nitrate of silver was applied.

Affections of the nasal duct and lachrymal sac produce conjunctivitis, the cause of which may be overlooked. Of course, no treatment here will avail, except one directed to the source of the trouble.

The distinction between catarrhal ophthalmia and scrofulous ophthalmia is, that in the former the cornea is not involved, the redness is diffuse, and there is but little photophobia or lachrymation, whereas, in the latter the cornea is usually involved, there is great photophobia and lachrymation, and the injection is most marked in the vicinity of the phlyctenulæ. The general condition of the patient has also an important bearing in this differentiation.

Dr. Michael said that one source of error (at least in his experience) had been omitted in the paper, *i.e.*, ciliary spasm, which tends to confuse those first attempting to apply glasses. He found it necessary to paralyze the accommodation with atropia before resorting to the optometer for the determination of the proper glasses, which is the method pursued at the Presbyterian Eye Hospital.

Dr. Theobald replied that general practitioners are not likely to attempt to apply glasses. Furthermore, spasm, to judge by his own experience, is extremely rare. In hypermetropia, at least, he would be at a loss to know what glasses to order if the muscles of accommodation were in a state of paralyzation. He never uses the optometer, believing it to be unreliable. It causes convergence of the axes of the eyeballs, even if one eye is examined at a time, and accompanying this there occurs an associated movement of accommodation, which causes hy-

permetropic patients to appear myopic. By testing with parallel optic axes at 20′ this mistake can be avoided.

Dr. Morris related a case of a lady of this city who was sent on by her physician to New York, to consult two eminent oculists of that city, for some obscure eye trouble. After their examination she overheard one of them say that her trouble was only hysterical. Thereupon she returned to Baltimore and Dr. Morris took her to see a specialist here, who declared that she was suffering from serious glaucoma and would lose her sight unless relieved by an operation. Iridectomy was therefore performed on both eyes. She has been well ever since.

In another case the oculist sent the patient back to Dr. Morris, saying that there must be some uterine trouble, which was confirmed upon vaginal examination.

If there be a relationship between affections of the uterus and eye we ought to know it.

Dr. Theobald had no doubt of the relationship, but had no personal experience to offer. He had had patients with asthenopia who had said they had uterine disease, but he had always been able in these cases to ascribe it to other satisfactory causes. He related a very remarkable case of apparent blindness in a *hysterical* young lady, the daughter of a physician, who became suddenly completely blind in both eyes. She was treated by local blood-letting, etc., but not improving, was sent to Baltimore to see him. Nothing was to be seen upon ophthalmoscopic examination. Her pupils acted normally, and she was in excellent health. Asafœtida tea, a wineglassful, warm, every half hour, was ordered; in two days she was well. There was no evidence of uterine trouble in the case. He has known functional disturbance of the eye to coincide with nocturnal emissions.

Dr. Erich had not been able to establish the relation referred to. In hysterical aphonia the suggestion of an emetic generally suffices, if made with positive assurances that it will be administered immediately if the patient do not speak out. The impression on the mind secures relief. The troubles of hysterical patients are not simulated, they depend upon a species of insanity. The battery produces a powerful effect upon hysterical women. It is employed at the Maryland Women's Hospital to keep such patients quiet; should it fail to do this, some organic affection is suspected and sought for.

Dr. Browne had seen many patients affected with uterine troubles suffer from asthenopia, but had always thought the general bad health was sufficient to account for it.

Dr. Hartman had always found hysterical aphonia associated with anæmia and debility, the patients being generally shop girls, school teachers, etc. The best remedy is the battery, a shock of which rarely fails to cause them to shriek out.

BALTIMORE MEDICAL AND SURGICAL SOCIETY.

Croup.

Dr. Coskery. Last Wednesday week I performed tracheotomy for membranous croup, on account of obstruction of the tube from blood, etc. I used suction four times before it was free. The child died eighteen hours after. Three days after the operation I suffered with all the symptoms of diphtheria, fever, prostration, patches on the tonsils and fauces, etc. These symptoms lasted several days. As I got well my child was taken with similar symptoms, and for three or four days was quite ill, but got well. I have been at a loss to know what to call these cases. I do not think they were true diphtheria, on account of the prompt recovery and lack of sequelæ; but think I was poisoned and am sure my child was. I do not believe in the identity of croup and diphtheria.

Dr. Scarff. I think a large majority of the cases of true croup can be cured if treated promptly. I have had a number of cases and have only lost two. I do not think croup is the sequelæ of another disease, and believe the false membrane is very seldom the cause of death, as is shown by the persistence of the dyspnœa after the removal of the membrane by emetics. The treatment I use is an emetic dose of turpeth mineral, repeated in ten or fifteen minutes, if necessary. I think it is more certain and not so depressant as tartar emetic. I follow with tinct. aconite rad., or tinct. verat. vir., given every hour, watching the effect. Hot sponges are applied unless great suffocative dyspnœa from contraction of the muscles. If the disease extends, give the stimulant expectorants, and in the latter stages quinine and carb. ammon. in large and frequent doses. I never use calomel. During convalescence I use chlorate of potassium and quinine; liquid nourishment from the beginning. The room should be moderately warm, and not too much covering allowed. I have treated thirteen cases on the above plan, and lost two.

Dr. Cathell. Smith says this disease is very fatal under any treatment. He recommends turpeth mineral and condemns calomel. In my cases I rely much on moisture. I have the room saturated with the steam from lime water. Internally I give iodide of potassium in large and frequent doses.

I think it is the most reliable remedy we have, and by it I have rescued children that were apparently moribund. In one case I gave eight grains every hour for twenty-four hours, and the child got well. I can recall five cases, in which death seemed certain, which got well after its use. In any case of croup I order two grains every two or three hours, and have not had a case pass into the membranous form since I began its use.

Dr. Evans. I would emphasize the use of potass. iod. I got the idea from its effects in asthma. I never use emetics; think they depress and do no good. I combine the iodide with bromide of ammonium and syr. senegæ and use in large doses. I have had three cases in the last ten days and they all got well under this treatment.

Scarlatina.

Dr. Brinton. I do not believe that scarlatina and diphtheria are identical, yet it has been my misfortune to lose a number of cases of scarlet

fever this winter, and nearly every case died from diphtheritic patches on their tonsils and fauces and false membranes in the air passages, forming what I call diphtheritic croup. Is this diphtheria engrafted upon scarlatina or not?

Dr. Bates. I look upon it as diphtheria attacking a child debilitated by scarlatina. We may see the same condition after any exhaustive disease, and we know that diphtheria may be the sequela of exhaustion, however produced. I lost one case from the same causes as described by Dr. Brinton. I know our president considers scarlet fever and diphtheria identical, but I think he is in error in so considering them.

Lumbago.

Dr. Reynolds. I wish to call attention to the use of the uterine pump as a substitute for cups, etc., in producing counter-irritation. I have used it in a number of cases of lumbago, muscular rheumatism, acute pleurisy, pain over ovary from chronic inflammation or irritation, and found it an efficient agent.

Dr. Morris. I have used it in uterine congestion and found it very useful.

Embolism.

Dr. Morris. A lady had been suffering for weeks from chronic malarial poisoning, but not so severely as to make her keep her bed. On last Tuesday labor took place and I delivered her of a small fœtus. Next morning she complained of dark spots on her neck. About ten hours after delivery I was sent for and found her dying. She had great dyspnœa and intense pain over the præcordia and died in one hour and a half.

Traumatic Tetanus.

Dr. Caldwell. A lady, twelve or fourteen days after miscarriage, was attacked by tetanus. The temperature was 107° to 108°; pulse 160; died in three days. Morphia, chloroform, calabar bean, etc., were used without benefit. Fortunately for the obstetrician these cases are very rare.

Rheumatism.

Dr. Evans. I wish to call attention to the use of large doses of quinine in the treatment of acute rheumatism. Lately I had a case in which the temperature was 110°, pulse 140. Large doses of quinine were used, and the patient recovered.

Nasal Catarrh.

Dr. Hamill. A man for five years had suffered from nasal catarrh. Almost everything had been tried without benefit, when he was recommended to plug the nostrils alternately with cotton. He found great relief from this simple treatment, and I call attention to it, so that others may try it.

Dr. Cathell. I have tried it and found it beneficial. I got the idea from a little article going the rounds of the press. A German was the originator, and had used it in fifteen cases; all got well; average duration of treatment twenty-one days. I have used it for about one year, and know of no case which has not been cured or greatly benefited. It gives rest to the irritated membrane. I do not use it in ozæna.

Dr. Arnold. A lady, nineteen years of age, two and a-half years ago had diphtheria, and as a result there was complete loss of voice. She could not speak above a whisper. She was treated by several specialists without benefit. She came under my care about four months ago. It could be seen, by the laryngoscope, that upon pronouncing a or e the right vocal cord came down well, but the left cord could not be seen. I concluded that there was paralysis. There was chronic catarrh of the mucous membrane covering the cartilage of Santorini; it was injected and thickened, but this would not account for the loss of voice. I was very cautious in my prognosis. I used a very weak interrupted current, one pole being applied over the lateral part of the thyroid gland and the other one near to it. A brush dipped in cold water was run down the throat, to produce mechanical irritation. After five weeks' treatment, with daily applications at first, she could speak distinctly. She then contracted a severe cold and again lost her voice. In about six weeks treatment, was resumed. She can now talk in an ordinary tone distinctly, and can sing. Upon examination with laryngoscope the left cord comes down distinctly but not enough to produce the chink, and does not stay down long enough, which shows that the paralysis is not entirely gone. Electricity is applied every day for fifteen minutes. All the letters are pronounced distinctly, except u and sometimes i. She has been ten weeks under treatment. Erb recommends this mode of applying electricity, while Mackenzie and others recommend internal application. She formerly had much pain in the neck and back of the head, whenever she made an effort to speak.

Dr. Billingslea. I have seen the internal application of electricity in two cases. In one the lady could not speak at all, and in the other the voice was lost for eighteen months. They were both cured.

Dr. Reid. Would not electricity give permanent relief in cases of hysterical aphonia?

Dr. Arnold. Frequently not.

Dr. Reid. I treated one case of hysterical aphonia by this means. One application was sufficient and there has been no trouble since.

Pilocarpin in Diphtheria.

The effect of pilocarpin in diphtheria is, according to various German writers most admirable. Dr. Guttman (*Allg. Med. Zeit.*, October 9th) says, that given internally a free salivary discharge is established, by which the diphtheritic membranes are softened and dissolved; the inflammatory phenomena rapidly lessen and disappear; and the condition of the patient is speedily improved. Out of sixty-six cases, many of them severe, he *did not lose one*, and they all were cured in from twenty-four hours to three days!

Editorial Department.

Periscope.

Chlorate of Potash in the Hemorrhagic Diathesis.

In the *British Medical Journal*, October 30, 1880, Dr. Alexander Harkin urges the value of the chlorate in constitutional hemorrhages. We quote a few of his illustrative cases:—

Hæmophilia: Epistaxis.—A. B., aged 18, tall, of florid complexion, engaged in a large concern near Belfast, established for the manufacture of the textile fabrics for which that town is remarkable, suffered so much from a continual dropping of blood from the nose, caused by dust from the flax, that he feared he should have to relinquish the business. His family history is remarkable, his father having been subject to many and severe attacks of epistaxis, sometimes persisting, in despite of treatment, for a month at a time. Another member of the family suffered in the same way after the extraction of a tooth; a wound on the skin, as by shaving, giving rise to most troublesome bleeding. Having been asked by a friend, in the end of 1874, to prescribe, *in absentiâ*, I ordered a mixture, which was forwarded to him, containing an ounce of the chlorate dissolved in twenty of water, but with the addition of one drachm of the tinctura ferri perchloridi. A fortnight after the young man called to thank me for his cure. Nearly five years have since elapsed without a relapse, save on one occasion, when, having lost a train, he ran a distance of two or three miles, when a slight bleeding occurred, which was staunched by his pocket-handkerchief.

Hæmaturia Renalis.—W. McN., aged 25, a saddler by trade, living at Albert Bridge Road, Belfast, of very delicate constitution and deformed spine, and subject to lumbar pains, consulted me in July, 1863, for a very profuse discharge of bloody urine which had troubled him for many months, and for which he had been treated ineffectually by several medical men. The blood came in large quantities, mixed, but not suspended, in the urine, apparently from the kidney; the bladder was healthy and free from calculus, having been carefully sounded by my friend, Dr. Murney. I tried for a time a number of styptics, etc., in vain, among the rest the tincture of iron; when, on recurring to my favorite remedy, and joining to the iron the chlorate of potash in the usual dose, immediate relief was the result. For a period of twelve years the man was subject to periodical returns of the affection, perhaps twice in the year. His custom was to have the prescription renewed, generally without reference to me, and with the same happy result; he was thus enabled to continue at his trade and to assist his friends, until the month of August, 1875, when, having taken a long drive upon a rough road, the hemorrhage recurred with great violence, and the attack terminated fatally in ten days. I had not the opportunity for post-mortem examination.

Purpura Hemorrhagica.—I was requested by some charitable ladies, in the summer of 1865, to visit a factory-worker named Hagan, who lived at 58 Mary Street, Falls Road. She had been confined to bed for thirteen weeks, and been carefully attended by the dispensary doctor of her own and the Shankhill districts. I found her much exhausted by a continuous drain of blood proceeding from the gums, nose, bowels, vagina and bladder. She was profusely covered with purple maculæ on the chest, arms, legs and abdomen. Her diet had consisted for months exclusively of bread and tea, alternated with rice, with little milk, potatoes being scarce and dear, and not having any one to cook them. I advised a complete change of diet, and prescribed the usual mixture. When I called to see her, at the expiration of a week, she opened the door herself, quite recovered, all bleeding having ceased ere the mixture was finished. As a later example I may give the case of Sarah Flanagan, aged 12, an inmate of the St. Patrick Industrial School, Belfast, whom I visited on May 8th, 1878, suffering from bleeding from the nose and gums, her body being dotted freely with the characteristic purple spots. In her case two drachms of the salt, with thirty minims of the tincture of iron, effected a cure, every trace of the disease having disappeared within a week. Her diet was, of course, looked after.

Menorrhagia.—Miss L., a school teacher, aged 38, wan and feeble, very tall and delicate, consulted me for a discharge of blood, which had continued, with short intervals, after a menstrual period several months previous. She suffered from severe pain in the back, from palpitation and the other constitutional symptoms consequent on a continuous drain. She had tried various remedies prescribed by other medical men without effect. I advised relaxation from her duties for a time, and the chlorate and iron mixture. I saw her some days afterward; her color began to improve, the discharge diminished, and finally disappeared. The mixture was renewed and taken occasionally as a preventive.

Gastrotomy.

Dr. L. L. Staton, of Tarborough, N. C., reports, in the *North Carolina Medical Journal*, for October, 1880, a successful case of gastrotomy, performed on a colored boy, eight years of age, who was, when the doctor first saw him, almost dying of hunger, on account of a cicatrized stricture of the œsophagus, the result of drinking, by mistake, a large quantity of a solution of concentrated lye. The operation was performed by dividing the skin for two and a half inches, in a diagonal direction, from right to left, under the cartilaginous portion of the eighth rib and as near the sternum as possible, but a finger's breadth from the median line. The walls of the abdomen were then divided in the same line, when two fingers were introduced to examine for the stomach, which was found firmly contracted, about two

and a half inches in length and about one and a half inches wide, feeling like a fibrous tumor. After drawing the organ out through the opening made in the abdominal wall; an incision about three-fourths of an inch long was made, parallel with the long diameter of the viscus, near the smaller curvature. One end (the inner flange) of a hard-rubber tube was now introduced into it and the stomach returned within the abdominal cavity, the outer flange being secured by means of silver-wire sutures. From the tube leads a soft-rubber pipe, about one-half of an inch in diameter, with a hard-rubber mouthpiece attached, making an artificial œsophagus. The operation was performed under the antiseptic spray, and a sixth of a grain of morphia in solution was next introduced into the stomach through the tube, the opening of which was then closed with a cork. Nutritive enemata were administered, and two days after the operation four ounces of milk were forced through the tube into the stomach, by means of a syringe. In this way it was gradually dilated and began to absorb and digest food, while at the same time the enemata were continued. The boy has since increased in strength and in flesh, without any peritonitis or other inflammation. In feeding, after thoroughly masticating his food, he simply spits it through the tube into the stomach in a semi-fluid state. At last account, nearly five months after the operation, the patient was doing well.

Influence of Light on Nutrition.

The influence of light upon the nutrition of the animal body is a subject which appears to have received more attention from the practical physician than from the physiologist—at least in this country. There are few persons who do not believe in the hygienic value of abundant light as well as of fresh air; but it is difficult to point to other than pathological or negative evidence in favor of this opinion. We have now at our command definite physiological facts respecting the influence of light upon the excretion of carbonic acid in the lower animals. These are the results of investigations carried out by Moleschott and Fubini, (*Centralblatt, f. d., Med. Wiss.*, 1880, page 562). By carefully arranged experiments these observers were able to estimate, not only the comparative, but the absolute or quantitative effect of light upon amphibia, birds, and mammals, and to exclude from the result the effects of temperature and movement. The result was in all classes of animals so far the same—the admission of light to an animal which had been previously kept in the dark raising the amount of carbonic acid excreted from 20 to 40 per cent., and from 11 to 27 per cent. even when the animal had been previously blinded. It thus appears, as we should have expected, that light affects nutrition not only through the retina, but also through the skin. What is more remarkable is that the nutrition of the muscular system, after removal of the skin, central nervous system, and eyes, was found to be 50 per cent. more active in light than in darkness; while the brain and spinal cord similarly tested showed similar, though less marked, nutritive activity under the influence of light. Further experiments showed that blue-violet light exercises precisely the same influence on nutrition as mixed (white) light; while red light affects frogs similarly to darkness, although it stimulates nutrition to a moderate degree in birds and mammals. The individual tissues proved to be affected by colored light in much the same way as the entire body.

Recent Observations on Hemianæsthesia.

A recent number of the *Lancet* contains some interesting observations, made by M. Grasset, of Montpellier, and others. One was the case of a man who was suffering from left-sided hemianæsthesia, alleged to be of six years' duration, and in whom right-sided anæsthesia had been previously and unexpectedly removed by a blister applied for pleurisy. The loss of sensation is supposed by M. Grasset to have been due to an organic lesion of the brain, but its course and the circumstances of the previous attack of right-sided anæsthesia, render it difficult to accept this view of the nature of the case. The application of a blister over the deltoid was followed by the return of sensibility in the greater part of the limb. The restoration did not, however, return first in the neighborhood of the blister, but in the hand, and it extended as far as a little above the elbow, the neighborhood of the blister remaining insensitive. Another blister was then applied to the thigh, and was followed by a recovery of sensibility in the whole leg. The loss of sensation was thus reduced to the left half of the trunk, neck, and face.

M. A. Robin found some time ago that saturnine hemianæsthesia could be removed by the action of jaborandi, the diaphoresis appearing to be attended with a return of sensibility. The use of the drug was also suggested by a statement made by M. Grasset's patient, viz: that when he was anæsthetic on the right side he only perspired on the left. Accordingly six grams of infusion of jaborandi were given. Perspiration was equal on the two sides. Immediately afterward no change in sensibility could be discovered; but twenty-four hours later, after severe perspiration during the night, sensibility returned in the anæsthetic parts.

The mode of action of diaphoresis in removing anæsthesia is a subject on which there is considerable room for divergence of opinion. M. Robin suggested that it is by modifying the vascularity of the anæsthetic parts. M. Grasset, however, rejects that opinion, on grounds supplied by the further history of his patient, who presented the oscillation so often noticed in cases of functional disease. Six days after the recovery of sensibility just mentioned there was a partial loss of sensibility on the left side of the face, passing away on the following day. A little later he had another return of partial anæsthesia in the left thigh, between the hip and the knee, which passed off after free purgation. A few days later he had another attack of partial insensibility in the same region, disappearing after three days' duration, with spontaneous sweating. This anæsthesia was just in that part of the thigh to which the blister had been ap-

plied. Still later anæsthesia occurred in the left arm and hand, sharply but irregularly limited, not according to nerve-distribution. A mustard-leaf was applied to the back of the forearm, and left in position for more than an hour, causing abundant redness, but no immediate influence on the sensibility. A few hours later, however, sensation gradually returned, the recovery commencing at the upper part of the limb. Another attack of anæsthesia was quickly removed by the application of the magneto-electric apparatus.

On Antiseptic Inflation.

Mr. J. Holden Webb, of Melbourne, has recently published a paper in the *Australian Medical Journal*, describing and advocating a new plan of rendering old sinuses and putrid abscess cavities aseptic. At first such cases were dealt with by injections of carbolic acid lotion; more recently Volkmann has introduced his sharp spoons, by means of which the unhealthy granulation tissue forming the walls of such passages and cavities can be removed; and inasmuch as there is good ground for believing that septic organisms not only exist in the putrid discharge, but also infest the secreting walls of such cavities, this must be considered, and, indeed, has proved, a valuable adjunct to the simpler plan of injections only. In dealing with very large cavities, irregular and sacculated, such as are particularly met with in connection with disease of the spine, it is obviously very difficult, if not impossible, to inject fluid so thoroughly that it shall penetrate into every corner and exert its germicide property on every part; and in these cases, also, the use of Volkmann's sharp spoons is necessarily limited within very narrow bounds. It was for such cases that Mr. Webb tried inflation with carbolized air, as being more likely to give success. His apparatus is simple. Into a Florence flask he puts some crystallized phenol, and through the cork, which fits tightly, he passes two glass tubes, one passing to the bottom of the flask, the other only just beyond the cork. These tubes are bent at right angles just above the cork. To the long tube a Richardson's bellows is fixed. When in use the flask is raised on a stand, the acid melted and heated by a spirit lamp, and air forced by the bellows through the acid in the flask, and by the shorter tube into the cavity to be inflated. All the force of the hand is used in the inflation, the cavities being tightly distended, and although it "often makes the patient drowsy for some hours afterward, and sometimes renders the urine smoky." Mr. Webb has not met with any ill effects. Thymol inflation has been followed by disagreeable sickness. In his paper, cases of old sinuses, spinal and other abscesses, submitted to this treatment, are detailed, and it is stated that the results in correcting septicity of discharge, and therefore in checking suppuration, fever, and hectic, and hastening recovery, have been very satisfactory.

Back Number Wanted.

We will pay 20 cents each for a few copies of the Reporter, No. 1037.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——Dr. Charles James Fox, of Willimantic, sends us an essay on "Chrysophanic Acid as a Remedy in Diseases of the Skin," which was read before the Connecticut State Medical Society, May 1880.

BOOK NOTICES.

On the Use of the Cold Pack, Followed by Massage, in the Treatment of Anæmia. By Mary Putnam Jacobi, M.D., and Victoria A. White, M.D. New York, G. P. Putnam's Sons, 182 Fifth Avenue, 1880. Cloth, 8vo, pp. 76. Price $1.25.

This volume is a reproduction in book form of a series of articles which have appeared in recent numbers of the *Archives of Medicine*. The observations made and the conclusions arrived at by the authors are based on a careful study of eleven cases of anæmia, some of which were more or less complicated by uterine and nervous disorders. It was found that the cold pack invariably increased the rapidity of tissue metamorphosis, as shown by a marked increase in the elimination of urea during the hours of the pack. This was followed by an increase in the appetite, weight and strength, the improvement being, however, less marked in those cases in which there was a nervous complication. Iron was administered in small and frequent doses (ferri and pot. tart. gr. j every hour). This the authors regard as a valuable remedy in conjunction with the pack and massage, but often insufficient by itself, as, in several of the cases recorded it had been taken for a length of time without the least benefit. The work is characterized throughout by scientific accuracy and philosophical reasoning, which is quite refreshing to find in the writings of women in these days of hasty generalization, when men search for facts to prove their theories, and frequently jump at conclusions from carelessly conducted experiments.

The information to be gained from this book will more than repay its persual. The adoption of the decimal system of weights in general, while the old system has been retained in some cases in speaking of doses, has led to some confusion; thus we are informed, on page 27, that "the patient was ordered tartrate of iron and potassa, three grams every three hours," when three grains undoubtedly must have been meant.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	**$5.00**
Half-Yearly Compendium of Med. Science,	**2.50**
Reporter and Compendium, - - -	**7.00**
Physician's Daily Pocket Record, - -	**1.50**
Reporter and Pocket Record, - - -	**6.25**
Reporter, Comp. and Pocket Record, - -	**8.25**

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

NEW EXPERIMENTS IN HYPNOTISM.

In a previous number of the REPORTER we have referred to the experiments in reference to the mesmeric condition carried on during the last year at Breslau, by Professors HEIDENHAIN and GRÜTZNER. At the last meeting of the German Association of Naturalists and Physicians, the latter gave an exhibition of this hypnotic condition. He chose twenty young people, scholars in the High School, seated them in two rows, and put in the hands of each a button of cut glass. They were instructed to look steadily at this button and to think of nothing at all. After five minutes he chose one and stroked him gently down the head, arms and breast. This he did to each of them three times, perfect quiet being enjoined. He would then ask one whether he was asleep or not. Out of the twenty some three or four were found to be appropriate subjects.

Such subjects would remain in uncomfortable positions when so placed; others would obey blindly the directions of the operator, while others again would be controlled by hallucinations of sight, hearing, taste or smell.

According to the report of those present, who embraced a number of the most scientific men of Germany, there is no room whatever for doubting that the condition exhibited is a strictly physiological one, and all possibility of simulation is out of the question. A discussion took place on the subject, without, however, throwing any additional light on the true theory of this phenomena.

In the course ot his remarks, Prof. GRÜTZNER stated that in the numerous experiments that he had performed he had observed the following fundamental types of hypnotism:—

1. A condition of peaceful sleep with consciousness and sensibility intact, in which the hypnotized person is merely unable to open his eyes. This condition is most frequently observed in weak persons and girls.

2. A condition chiefly characterized by rigidity of the muscles, either of the whole body or of a single limb. This is more frequent in strong subjects, as gymnasts, soldiers, etc. The muscles can be so stiff, for example, that a subject will sit in a chair and stretch out a leg so fixedly that a person can be supported on the foot for a considerable time, a feat wholly impossible in ordinary conditions. Such subjects cannot walk well nor speak well, on account of the stiffness of the muscles of the limbs or throat.

3. A condition of automatism, in which the subject renders absolute obedience to the orders of the operator. Frequently the subject is aware that the orders are disagreeable, but he cannot refuse to obey them.

4. The condition of hallucinations. This is more rare than the previous forms, but when present may be carried to any extent.

Prof. Grützner also discussed the question whether these experiments are dangerous to the subjects. The late Prof. Bennett, of Edinburgh, decried them severely; Prof. G., on the other hand, says he has never seen any bad effects result from them, except that they fall into this condition much more easily. For example, one of his subjects happened to look fixedly at a black bean in his soup, and forthwith fell into a trance. His comrades thought he was dead, but

he was immediately restored by blowing in his face, which is the most prompt means to break up the mesmeric sleep.

Several observers present stated that mesmerized persons developed faculties unknown to their waking hours. For example, one pronounced the most difficult sounds in foreign tongues, which he could not at all do when awake. Another, Dr. Cohn, of Breslau, has proven that persons who are color blind can distinguish colors correctly when hypnotized; and, on the other hand, some who are not color blind become so when under this influence. It is quite possible to hypnotize a single eye and leave the other normal, so that the subject will be color blind with one eye and not with the other.

Although facts akin to these have been known to the profession for a century, they have never received the attention from scientific students which they merit. They have been relegated to charlatans and considered beneath the dignity of the learned. This is surely a great error. A thorough classification and analysis of these nervous displays might very probably lead to important results in neurology and mental science. We commend them to the attention of students of these branches.

Notes and Comments.

Therapeutical Notes.

MIST. IN CHLOROSIS (SIREDEY).

℞.	Ferri citrat.,	℥j-gr. xv	
	Potass. bromid.,	℥iiss	
	Vini xerici,	℥viij.	M.

Fiat mist.

SIG.—Tablespoonful before meals.

PILLS IN HEMICRANIA (DEBOUT).

℞.	Quiniæ sulph.,	gr. 1	
	Digitalis pulv.,	gr. xxij	
	Syrup. simp.,	q.s.	M.

Ut fiat pil. No. xxx.

SIG.—One at bedtime for three months.

The Detection of Organisms in Water.

It is often a difficult task to discover microscopic organisms in water. Fortunately some chemical re-agents kill these organisms without changing their appearance; osmic acid is of especial value for this purpose. Once destroyed, they sink to the bottom, and if enough of the liquid has been employed, they may thus be collected in appreciable quantity. The value of this method is shown by the following experiment. If a test tube be broken, and the water it contained be contaminated by dipping into it the extremity of a rod which has been placed in an infusorial liquid, and it is then treated with osmic acid, the organisms will be found intact, and with readiness by the aid of a microscope. In the examination of water may be used a one-and-a-half per cent. solution of osmic acid. One cubic centimetre of this solution will suffice for thirty or forty centimetres of water, all animal and vegetable organisms being by it rapidly killed and fixed. In a few minutes, in order to lessen the blacking action of the osmic acid, as much pure water as the test tube will hold is added. In certain waters rich in organisms the microscopical examination may be made in a few hours. If the water be comparatively pure, twenty-four or forty-eight hours must be allowed to pass. The liquid, with the exception of the last one or two centimetres, may then be decanted. The detection of the organisms in the residue is facilitated by the employment of coloring agents, such as picrocarmin, methyl violet, and logwood.

Atropia in Chloroform Narcosis.

We find this subject but casually referred to in treatises on anæsthetics. It has, however, been worked out by Professor T. R. Fraser, of Edinburgh, who has shown atropia to be a cardiac stimulant, advisable when chloroform is to be given. It stimulates the heart, not only indirectly, by lowering the conductivity of the cardiac terminations of the vagi, and thus, of course, diminishing their inhibitory power, but also directly by stimulating the intra-mural motor ganglia of the heart; and possibly, also, by raising the excitability of the accelerator nerve to the heart from the cervical sympathetic ganglia; and perhaps it may even stimulate the cardio-motor centres in the medulla oblongata. Dr. Fraser considers it advisable to combine with the atropia a little morphia, say $\frac{1}{120}$ to $\frac{1}{60}$ of a grain of sulphate of atropia, *i. e.*, one to two minims of liquor atropiæ sulphatis (*B. P.*), and one-twelfth to one-eighth of a grain of acetate or hydrochlorate of morphia. These are injected about fifteen or twenty minutes before the administration of chloroform is begun; and by this means, (1) not only is the patient in a less nervous state when the inhalation is commenced, but (2) less chloroform is required, and, (3) moreover, a very objectionable evil is got

rid of, or, at all events, ameliorated, viz., the emesis which is apt to occur with chloroform.

Motor Nerves of the Eyes; Their Origin.

In the *Gazette des Hôpitaux* M. Math. Duval reports the following observations as to the origin of the oculo-motor nerves. The nuclei of the origins of the fourth and sixth pairs of cranial nerves are connected together by bundles of fibres, the arrangement of which explains the complicated physiology of the associated ocular movements. A very marked bundle goes from the nucleus of the third pair to that of the sixth of the opposite side; thus we can understand the simultaneous contraction of the right internal rectus and the left internal rectus and inversely. This bundle is double in the ape; one of its branches enters the nucleus of the patheticus. This nerve, therefore, takes its origin partly from the muscles of the external motor oculi; hence there is nothing astonishing that it enervates a muscle rotating outward, such as the superior oblique. In movements of lateral inclination of the head, this nerve acts simultaneously with that of the inferior oblique of the opposite side, but in an inverse sense. But the nucleus of the patheticus blends itself with the posterior part of that of third pair, the point of origin of the motor oculi communis, which innervates the inferior oblique and the patheticus itself, decussating in the valve of Vieussens, passes to the superior oblique of the side opposite to that on which it seems to rise The simultaneity of action of the two oblique muscles in question is thus explained by the community of origin of their different nerves.

On Ergot in the Intestinal Hemorrhage of Typhoid Fever.

In a memoir on the above subject (*Journal des Sciences Med. de Louvain*, September, 1880), M. Flandrin first considers the period of production and causes of the hemorrhage; generally coming on from the twelfth to the twenty-fourth day; it is much more dangerous coming on late in the disease; out of twenty-three cases of early hemorrhage (*Dubuclet, Thèse de Paris*, 1872) but three deaths occurred, while the same author found that twenty-two deaths resulted in twenty-two cases of late hemorrhage. The cause of the hemorrhage is primarily the fluidity of the blood, together with the ulcerations affecting the vessels of Peyer's patches, and the fatty degeneration of these same vessels; the proximate causes are premature alimentation, cold baths, or some muscular effort on the part of the patient.

The quantity of blood lost is often very large, and all the symptoms of collapse usually coming on after great losses of blood, such as pallor of the face, fall of temperature, frigidity of the extremities, and thready, accelerated pulse, may come on before blood appears at all in the stools.

A notable but evanescent amelioration occurs frequently just after intestinal hemorrhage, and Trousseau and Graves regarded it as a critical symptom of favorable augury, and did not favor its arrest; an exactly opposite opinion has been held by Murchison, Griesinger and Jaccoud, who earnestly recommend active and immediate remedial action.

The good results obtained from ergot have been principally made known by Murchison; it may be administered in any form, but principally hypodermically in form of ergotine.

In four cases of abundant hemorrhage occurring in the service of M. Sée, at the Hotel Dieu, and particularly in one very severe case, complicated with hæmatemesis and purpura, which had not been benefited by perchloride of iron, or spirits of turpentine, or formiate of soda, after the first day of ergotine injections (about one grain at a time) a notable amelioration was observed, and after the second the hemorrhage was arrested and did not return.

Conservative Treatment of Sympathetic Ophthalmia.

M. Bouchut in the *Gazette des Hôpitaux* observes that sympathetic ophthalmia is most probably produced by transmission through the ciliary and optic nerves, and proposes the section of these nerves, as a substitute for the enucleating method. The operation was successfully performed on dogs, cats, and even rabbits, experimentally, the eye whose nerves had been cut being retained.

The operation consists in making a slight incision in the conjunctiva, severing the tendon of the external rectus muscle, and passing behind the eyeball with scissors sharply curved on the flat. The eye being drawn forward and turned inwardly, the optic nerve is put on the stretch, seized between the blades of the scissors and cut, together with the ciliary nerves. The eye is rotated still further in the same direction for examination, to insure the section of all the nerves, then the muscle is replaced, sutured, and an antiseptic dressing employed.

Optico-ciliary neurotomy, as the author calls it, has been performed in more than forty cases successfully, and is said to be an acquisition to conservative surgery.

Treatment of Chronic Cystitis.

In a very complete article on "Chronic Cystitis," in the *Dictionnaire Encyclopédique, des Sci. Med.*, M. Chauvel indicates the following preparations :—

℞.	Turpentine,	℥ ss.	
	Camphor,	gr. xv	
	Ext. hyoscyamus,	gr. ¼.	M.

Sig.—The ingredients are to be well mixed, and a piece the size of a cherry stone taken morning and evening.

Thompson frequently prescribes, with success, an infusion which he had seen an American use with benefit. It can be given in all forms of chronic cystitis :—

℞.	Uvæ ursi fol.,	℥ j-ij.	
	Pareiræ. bravæ. rad.	℥ j-ij.	M.

Sig.—Boil in a quart and a-half of water to a quart. Take from f. ℥ ij to f. ℥ iv, four or five times a day.

M. Gosselin recommends benzoic acid, to prevent the development of ammonia. He gives at first 15 grains per diem, gradually increasing to 60 and even 90 grains, without causing any trouble, save a slight parching of the throat. This treatment generally neutralizes the acidity of the urine after seven or eight days.

Convenient Decalcified Bone Drainage Tubes.

The use of drainage tubes made from decalcified bone is not new, but is growing in favor. A convenient method of obtaining them is suggested by a correspondent of the *Lancet*, Oct. 30th, 1880. He writes :—

In the long bones of the limbs of poultry and small birds I have found capital drainage-tubes ready turned to hand. The bones, collected by the cook and well boiled, to free them from the soft parts, are soaked for about ten hours in a mixture of one part of hydrocholoric acid and two parts of water. Immersed for this time, they become sufficiently soft and flexible for use, and to be cut with ordinary scissors. The ends of the bones are now cut off with a pair of scissors, and the medullary canal well cleaned out with a thick wire or rat-tail file. The bone tubes should then be boiled in a five per cent. solution of carbolic acid, to which some borax—an antiseptic procurable in every store at a very cheap rate—has been added. The tubes are to be kept in a five per cent. solution of carbolic oil. If the ends of the bones are cut off with bone-nippers before being decalcified, they are very liable to split. If soaked too long in acid, the walls of the bone tube become too soft and gelatinous, and the lumen is liable to be closed by the pressure exerted by the edges of the wound into which the tube is inserted.

The Varieties of Vaccinal Eruptions.

A report on these eruptions was presented last summer to the Paris Academy of Medicine, by Dr. Hervieux. He classifies them as follows :—

1. Vaccinal eruptions are of two kinds: those caused by accidental inoculation, as by the nails, accidental pricks with the vaccinating instrument, etc. ; and those resulting spontaneously, as in the exanthemata, from general infection the system.

2. Spontaneous vaccinal eruptions may be primary, appearing simultaneously with the vaccine vesicle proper ; or they may be secondary developing at a later period, usually the ninth or eleventh day. In the first case the eruption presents the same character as the ordinary vaccine vesicle ; in the second case it assumes very various forms ; erythematous, miliary, vesicular, papular, etc.

3. In patients subject to eczema, impetigo, or chronic diseases of the skin, the vaccinal eruption, generally mild and discrete, readily takes on a graver character, becomes confluent, and is generally limited to the parts affected by the cutaneous disease.

Correspondence.

Alcohol in the Blood.

Ed. Med. and Surg. Reporter.

Perhaps the following notes may be of interest to some of the brethren, as exhibiting the impermanency of the admixture of alcohol and blood, and in that much proving the inutility of alcohol as food. They—the notes—were given me by the son of Mr. G., whose veracity is undoubted :—

James G., aged 45 years, an habitual periodical drinker, was accustomed to get on a spree every six or eight weeks, and would continue drinking for two or three weeks, when he would commence to sober up, at which time—as he claimed, to assist the sobering—he would have himself bled freely from the arm. At one of those bleedings, his son—my informant—holding the vessel to receive the blood, was struck by the odor of the blood being so strongly alcoholic, and concluding to see for himself if it was alcohol *in* the blood, he set the vessel containing the blood aside for a couple of hours, when there was found floating upon the coagulated blood a liquid resembling alcohol, and which burned with the characteristic flame of alcohol. I do not remember to have ever seen an account of free alcohol being found in the blood, and as this so nearly approaches it, I report it for what it is worth.

L. J. Collins, M.D.

November 22, 1880.

News and Miscellany.

Meeting of the American Public Health Association.*

FIRST DAY.

The Association met, December 7th, in Grunewald Hall, New Orleans, Dr. John S. Billings, of Washington, in the chair. Over four hundred members were present. The opening prayer was made by Rev. J. N. Galleher, Bishop of Louisiana.

After the election of new members, two papers were read on abattoirs, by Dr. Devron, of New Orleans, and Dr. Bushrod W. James of Philadelphia.

Dr. Smith, of the United States Army, read an interesting article on the Texas cattle fever, which, after a brief discussion, was laid aside to receive the report of the Committee on a Plan for the Prevention and Limitation of Contagious Diseases.

Dr. Albert L. Gihon, Medical Director U. S. Navy, read the report, which closed with the following resolution, which, after some discussion, was adopted:—

"*Resolved*, That the American Public Health Association earnestly recommend the municipal State Boards of Health to urge upon the Legislative bodies of this country the enactment of a law constituting it a criminal offence to knowingly communicate by any direct or indirect means a contagious disease, such as smallpox, scarlet fever, or venereal disease, and giving to said Boards of Health, and to the State and municipal health officials under their control, the same power in the prevention, detention, suppression, and gratuitous treatment of venereal affections which they now possess in the case of smallpox and other contagious diseases."

A paper on the storm water question in relation to sewage, was read by Col. Geo. E. Waring, of Rhode Island. The Colonel contended, in his paper, that the plan of getting rid of storm water in cities and towns, by means of deep sewers was objectionable and pernicious to health, because of the organic matter passing through them, much of which is left near the man traps and at corners of the streets. He proposed, as a remedy, that the gutters be so constructed as to allow all the storm water to pass without interfering with traffic.

Dr. White, of Milwaukee, was satisfied that sewage proper should be kept distinct and separate from storm water, not only on the score of economy, but so as to reduce the amount of sewer gas which originates from putrefying matter in the sewers. He said that New Orleans could get rid of its sewage proper by means of wooden pipes that could be laid in the water, leaving the storm water to flow in the gutter as at present. A paper upon the action of muddy water upon sewage was read by Prof. Brewer, of New Haven.

Dr. Walcott read a paper written by Dr. James Rane, of Brooklyn, N. Y., on the prevention of certain contagious diseases by the Local Boards of Health. The paper was one of great length, and discussed thoroughly the means that had been adopted by the Board of Health in his city.

SECOND DAY.

Early in the session a discussion ensued upon the report made yesterday by Dr. Gihon, at the close of which the following resolution was adopted:—

Resolved, That the Executive Committee be instructed to communicate with the State and municipal Boards of Health throughout the country, and supply them with a copy of the report of the Committee on the Prevention of Venereal Diseases, and request their coöperation in the attainment of the objects of the resolutions submitted by the Committee and adopted.

The following resolution was also adopted:—

"That a committee of five be appointed to prepare and recommend measures for the more efficient management and control of future epidemics, especially for the training, selection and employment of skilled and trustworthy nurses."

Dr. Billings read the report of the Advisory Committee on national sanitary legislation. The report gave an account of the proceedings taken by the Advisory Committee during the past year. The first portion treated of the sanitary bills before Congress, especially bills relative to the International Conference on quarantine, and the bill to increase the efficiency of the National Board of Health. The National Board had no desire for increase of power over quarantine, but were willing to await the result of the International Conference. The Advisory Committee are of the opinion that it is not desirable that the Association should recommend any change in the existing legislation affecting the National Board of Health, but advise that Congress should be recommended to make suitable appropriations for the work of the National Board, and authorize the prompt publication of the reports. The Advisory Committee suggested for consideration the subject of the adulteration of foods and drugs by the International Quarantine Conference which assembles in Washington next month. The report was received and adopted.

Dr. G. B. Thornton, of Memphis, read an interesting paper on the "Sanitation of Memphis," showing the improvements made in its sewage system, street paving, cleaning, etc.

Col. Waring, who spoke on the subject, said the Memphis system, in its general features, could be applied to New Orleans. A paper on the "Valuation of Sanitation," from an economic standpoint, prepared by Col. Keating, of Memphis, was also read.

A paper on the "Sanitary Urgency of the Florida Ship Canal," by Prof. Jno. Gamgee, of Washington, D.C., was read. The paper claims that the shutting of this canal would prevent the introduction of yellow fever into New Orleans, that is now brought by ships passing through the Carribean Sea.

A paper on "Sanitation of Emigrant Ships," written by Dr. Turner, of the United States Navy, was read by Dr. A. L. Gihon. The paper concluded with a suggestion that, as most of the

* We are largely indebted for this report to the efficient pen of Mr. Coleman, special correspondent of the *Public Ledger*, of this city.

emigrants are brought to our shores under foreign flags, an International Congress be had, in order to secure all the benefits that the sanitary science of the day presents.

Interesting papers on "Dengue, or Breakbone Fever," were read by Dr. D. C. Holliday, of New Orleans; Dr. G. G. Thomas, of Savannah; T. P. Porcher, of Charleston, and Dr. Hoilbeck, of the same city. Dr. Burns, of New Orleans, read a paper on the "Fever of the Lower Coast."

In the evening, Dr. Hunt, of Trenton, N. J., read a paper on "Epidemics;" Hon. Jno. Eaton, of Washington, on "Sanitation and Education," and Dr. Elisha Harris, of N. Y., one on "Domestic Pestilences."

THIRD DAY.

The Public Health Association commenced its third day's proceedings at 10 o'clock. A resolution was adopted, that the Advisory and Executive Committees take under consideration the advisability of establishing a national museum of hygiene; also one commending the organization of auxiliary sanitary associations.

The following officers were elected for the ensuing year:—President, Charles B. White, M.D., of New Orleans; First Vice President, R. C. Kedzie, M.D., of Lansing, Michigan; Second Vice President, Henry F. Campbell, M.D., of Augusta, Ga.; Secretary, Azel Adams, Jr., M.D., of Massachusetts; Treasurer, J. Berrien Lindsay, M.D., of Nashville, Tenn. Executive Committee: Dr. D. C. Holliday, of New Orleans; Dr. E. M. Hunt, of Metuchen, N. J.; Dr. George M. Sternberg, of U. S. A.; Dr. E. L. Griffin, of Fond Du Lac, Wis.; Dr. J. R. Thomas, of Savannah, Ga.; Dr. Thos. F. Wood, of Wilmington.

The following papers were then read, "On the Relations of Schools to Diphtheria," by Dr. Baker, of Michigan; "On Municipal Sanitation as practiced in Mobile," by Dr. Scales; "On the Results of Attempting to Check the Spread of Smallpox in Chicago," by Dr. Dewolf; "On the Relations of Certain Filth Diseases to Cold Weather," by Dr. Dell, of New York. Papers were also read by Dr. Atchinson, of Tennessee; Prof. Chaillé, of New Orleans; and Hon. Erastus Brooks, of New York.

FOURTH DAY.

After prayer and election of new members, the following resolutions, presented by the Executive Committee, by Dr. Harris, of New York, were adopted:—

Resolved, That this Association recognizes and earnestly commends the efforts of the National Board of Health to secure practicable laws of uniformity for the nature and nomenclature of diseases and causes of mortality, and again urges upon all State and local boards of health and upon other public authorities, the medical profession and all members of this Association, to do whatever they can to promote such uniformity and thoroughness.

Resolved, That a committee of three members be appointed to have this subject under consideration, for the purpose of reporting progress and plans relating thereto at the next annual meeting, in coöperation with the National and State Boards of Health, and with the medical and statistical bodies that have this subject under consideration.

Resolved, That systematic sanitary surveys and inspection are essential aids to successful public health works, and to the progress and application of sanitary science; therefore this association urge upon such local authorities the importance of such surveys, and the sanitary maps and records that pertain thereto, and also would recommend that the registry of prevalent diseases and mortality be made, as frequently as practicable, so coördinate therewith as to disclose the presentable causes which need to be removed.

Resolved, That the contagiousness of diphtheria is so established, that that disease should in all cases be treated with the same rigorous isolation and quarantine that is everywhere enforced against smallpox.

Resolved, That as we know little or nothing of the origin of diphtheria, we will request the National Board of Health to continue its investigation into the causes of this disease.

The following, offered by Dr. Henderson, of Kentucky, were agreed to:—

WHEREAS, There are annually occurring in our own large centres of population, and frequently in the provincial districts, numbers of cases of sickness and death from smallpox; and,

Whereas, the only certain method of restraining and preventing this loathsome disease is by vaccination and re-vaccination; therefore, be it

Resolved, That the boards of health of the several States in the Union, or, where no State boards of health exist, the State Medical Society, be requested to take the matter under immediate advisement, and direct the attention of all local boards of health to the importance of vaccinating all persons in their respective districts not previously vaccinated.

Resolutions were also adopted providing that for the better protection of public health, the Legislatures of the several States be invoked to enact measures imposing severe penalties against any person who, while suffering from any dangerous contagion or infectious disorder, willfully exposes himself, without proper precaution against spreading the said disorder, in any street, shop or other public place, without the persons so diseased shall notify the owners of buildings, or conductor or driver of vehicles or other conveyance that they are so suffering; also to impose a penalty upon any person who, being in charge of any one so suffering, shall willfully and knowingly expose such sufferer.

Professor Chaillé, of New Orleans, read an interesting summary of the conclusions of the Havana Yellow Fever Commission. After a discussion upon the paper relating to Yellow Fever, Dr. White, of New Orleans, the newly-elected President of the Association, was introduced and returned thanks, soon after which the Association adjourned.

The Quarantine Convention.

This Convention met each day, after the adjournment of the Public Health Association. It

was composed of delegates from some of the Western States, and those along the Mississippi Valley, and assembled for the purpose of discussing subjects vital to sanitary and commercial welfare. In addition to the delegates sent directly to this Convention, a number of the members of the Public Health Association were present by invitation.

Dr. Jones, President of the Board of Health of this city, called the Convention to order. Governor Wiltz, of Louisiana, delivered an address of welcome on behalf of the State, and Hon. Mr. Patton, Mayor, on behalf of the city.

On the second day the Convention elected Dr. Geo. A. Ketchum, of Mobile, Permanent Chairman. Delegates from the following States answered to their names: Alabama, Texas, Mississippi, Tennessee, Arkansas, Kentucky, Georgia, Florida, Louisiana, Maryland, South and North Carolina, Missouri, Indiana and Ohio. After the Committee on Credentials had reported, a motion was made to include Pennsylvania as one of the States to be represented, but it was stated that no invitation had been extended to that State, and, therefore, they had no accredited delegates.

Among the questions submitted for discussion were: Of what shall quarantine consist; when to be established and for what period; against which ports or countries; what diseases shall be considered as infectious or contagious; what is the best method of disinfection for ships and their cargoes; necessity for the adoption and enforcement, by the different States of the Mississippi Valley, of a code on quarantine and sanitary measures, which would obviate many difficulties and misunderstandings, and greatly promote inter-State commerce and business relations.

On the last day the Convention adopted the following resolutions:—

Resolved, That the Chair appoint two committees, to consist of seven members each, one committee to represent the Atlantic and Gulf States, and one to represent the States of the Ohio and Mississippi Valleys, each committee to prepare a schedule of rules and regulations concerning those matters of quarantine and sanitation which are common to the States of each region respectively, and which schedule shall be submitted to each of such States for ratification and adoption, as the basis of action for the protection of the public health, no State to have more than one representative on either of said committees.

Resolved, That it is the duty of the general Government to defray the expense of all quarantine administration of this character, that is, which extends beyond the boundaries of a single State, and said committees are hereby authorized and instructed to take the necessary steps to secure adequate appropriations by Congress for this purpose, such appropriations to be disbursed and expended in accordance with the usual Treasury regulations concerning disbursements and expenditures.

The Sanitary Council of the Mississippi Valley, Held a meeting December, 9th. The Boards of Health of Wisconsin, Kentucky, Iowa, Illinois, Minnesota, Michigan, Tennessee, St. Louis and the National Board were represented in the Council.

Dr. R. C. Kedzie, of Michigan, gave a brief history of the Council, and stated that it was organized for the purpose of counseling together and arranging a definite plan of co-operation should events render it necessary to establish a quarantine.

After some discussion the following resolutions were adopted, after which the Council adjourned until next day.

WHEREAS, Experience has shown that measures of quarantine under the sole direction of local and State boards of health have not succeeded in protecting this valley from invasion from yellow fever; and whereas our people habitually view with distrust all announcements which are of a character to affect the commercial interests of the locality directly concerned;

Resolved, That, in our opinion, the general Government alone, acting through its constituted sanitary agents, should have the direction and control of national and maritime quarantine.

On Friday the following resolutions, submitted by Dr. J. H. Rauch, of Illinois, were adopted:—

WHEREAS, There is, unfortunately, a want of confidence with regard to the prompt furnishing of information by the health authorities of New Orleans, with reference to infectious and contagious diseases; therefore, be it

Resolved, That, in the opinion of this Council, it would undoubtedly tend to the restoration of confidence if the State Board of Health would request the National Board of Health to place an inspector at quarantine in New Orleans, who shall have access to the records of the Board of Health and be furnished every facility for obtaining reliable information with regard to all cases deemed suspicious, and especially with regard to yellow fever.

Items.

The Report of the meeting of the Public Health Association, has crowded out a quantity of correspondence, news, etc. These will appear at the earliest practicable opportunity.

MARRIAGES.

CRAWFORD—MAGEE.—At Martinsburg, Pa., December 1st, by Rev. W. J. Gleson, D.D., S. Morrow Crawford, M.D., of Youngsville, Pa., and Marian Magee, of Martinsburg.

HARBISON—BUCKWALTER.—On Wednesday, December 1st, 1880, at the residence of the bride's parents, Limerick, Montgomery County, Pa., by Rev. J. Neff, Dr. A. B. Harbison, of Spring City, and Jennie, eldest daughter of Harry Buckwalter, Esq.

DEATHS.

DIXON.—In New York city, on Tuesday, December 7th, Edward H. Dixon, M.D., in the 72d year of his age.

WILCOCKS.—In this city, November 10th, Alexander Wilcocks, M.D., in his 64th year.

WHITBECK.—On Wednesday night, December 8th 1880, Dr. J. F. Whitbeck, of Rochester, New York.

THE

MEDICAL AND SURGICAL REPORTER.

No. 1243] PHILADELPHIA, DECEMBER 25, 1880. [Vol. XLIII.—No. 26.

Original Department.

Communications.

LOCAL TREATMENT OF DIPHTHERIA.

BY J. R. BLACK, M.D.,
Of Newark, Ohio.

Those who, like myself, have read thousands of articles on diphtheria within the last twenty-five years, may be disposed to turn in disgust from another article on a subject so trite and threadbare. Were it not that I have a local application of my own devising to present to those who have as yet found nothing satisfactory, I would save myself the trouble of adding to the immense mass of printed matter on the subject, which in a decade or two must inevitably be thrust into the fire as mere waste paper. In saying this, I by no means imply that such literature is useless in its day—as it is an undoubted means of educating the minds of medical men to broader and more discriminating thinking, if not to better practice. If there is any complaint to make of the literature on the subject, it is on the score of crudeness and verbal quibbling. For example, I have just read the statement of a physician, who says "that we may often have a diphtheritic deposit without the slightest constitutional disturbance."* Now, I have treated cases every year, for the past twenty-five—passing through two epidemics the while—and have never yet seen such a case; I have often seen, from slight tonsillitis, patches and strings of adhesive mucus or matter on the tonsils, especially in the morning; but, in an hour or two, after hawking or swallowing food or drink, they were no longer there, or by taking a throat swab they could be wiped away, just as like patches may be from the nostrils of a dirty urchin.

In no other light than verbal quibbling can I view the dispute now going on, whether croup and diphtheria are distinct diseases. Suppose that the exudations in each are homologous, with perhaps an occasional excess of micrococci in that of diphtheria; what then? Is their identity proved? Let us see. A half dozen of tracheas with diphtheritic, and another half dozen with croupous exudations are laid before the pathological anatomist, and he says he can discover no characteristic differences. This is the strong point of their unity.

Grant the point all its force, what is its logical significance? Cut a half dozen of non-specific ulcers and half a dozen of syphilitic ones, from the subjects of each, and lay them, without any history, before the pathological anatomist, and he would be unable to say which are the specific and which the non-specific; and being so, is he justified in saying that the morbid states of all were identical? Quite as much in the latter as in the former instances.

The chief glory of diagnosis of recent over mediæval medicine is an acuter perception of dissimilarities in similarities, or the separation into distinct phases of morbid phenomena those which the older writers regarded as one; and now some writers are attempting to huddle together two groups of distinct phenomena, which have only in common a histological similarity and nearness, not identity of place. Set out next, gentlemen, to prove that all forms of cutaneous inflammation are erysipelatous, or vice versa. Without going into any argument on the

* *Lancet and Observer*, November 6th, 1880, p. 405.

subject let us look at the manifestion of the two diseases differentially.

CROUP.	DIPHTHERIA.
A strictly sporadic and non-infectious disease.	Infectious among the young to a high degree.
May be more prevalent over a continent one time than another, from meteorological conditions.	Atmospheric causes non-efficient. Occurs as a household infection endemically or epidemically.
A disease of the purely sthenic type.	Markedly asthenic.
Almost exclusively occurs during infant and early childhood life.	Scarcely ever attacks infants: commonly between the second and twentieth year.
Primary site almost invariably in the larynx.	Primary site almost invariably on the tonsils.
Symmetrical.	At outset invariably asymmetrical.
Usually begins like a cold, with cough, slight vascular disturbance and febrile movement, distinct only in the evening.	Inception abrupt, with rigors, high fever, no cough and rapid pulse.
No tumefaction of cervical and sub-maxillary glands.	Invariably tumefied.
Respiration hurried and voice hoarse.	Respiration not accelerated, apt to be clogged, and voice resonant, or at most nasal, unless the disease extends into the larynx.
Death by apnœa.	Only by apnœa when the larynx becomes involved; may take place from blood poisoning.
Sequelæ of recovery only those common to any other phlegmasia.	Local paralysis quite common and pathognomonic.
One attack does not protect against another.	Does protect.

With this protest I come, as I have said, reluctantly, to add to the vast mass of literature on treatment, from those who rely on whisky, on the one hand, to those who rely on calomel, on the other. I cannot attempt to fathom the gap between these two or reconcile the implied confidences of each, much less to explain how it can be that both are said to be equally successful. 'Tis something to be ashamed of, this clashing of swords among the knights of medicine—this one contending that the enemy can best be vanquished by pulling down its stronghold; the other, by holding it up. I shall outline my constitutional plan in a single sentence, as there is not enough of novelty or merit in it to blacken your pages more. Moderate fever, keep the outlets of the body open, and support the strength.

The only novelty I have to present is the application that should be made to the diphtheritic surface. In 1854 I began with the then popular remedy, nitrate of silver; from that I diverged to potassium chlorate, with the muriate tincture of iron; afterward, chromic acid, iodine or tannin were now and then used; but not always by any remedy with satisfactory results; in fact, in many cases, quite the contrary, as, when called in time, with the exudation limited to the area of a single tonsil, I did not prevent the disease from spreading, not only over the fauces up into the posterior nares, but into the larynx, with an invariably fatal result, save in two instances. But for the last eight years I have used a compound that, so far, has never failed; albeit the number of cases submitted to my care during that time has not been large. The only one I lost was the little son of a German clergyman, himself having some pretensions to medical knowledge, and treating the case several days before I was called; the exudation, in the meantime, had extended into the larynx. Two sisters of the boy, soon after seized by the disease, were saved by timely treatment. The compound I use is the following:—

℞.	Glycerinæ,	℥ ss	
	Tr. iodinii,	℥ ss	
	Acid. salicylic.,	grs. xx.	M.

The acid is readily soluble in this vehicle and forms a very sightly, non-irritating and pleasant application. It should be applied freely, with a large camel's hair brush, morning and evening, carefully covering the whole of the diphtheritic surface with it. The brush should be well wiped each time after use. Of course, any application to a very tender part frightens little ones, and the itching produced by the mere contact of the brush with the fauces is far from pleasant. Yet a hand with a delicate touch and a physician with a persuasive tongue will readily succeed in doing his work well. I remember the third case in one family I had under my care not long ago; a little girl of some five summers. She could not make up her mind to let me apply the brush and medicine to her throat. Her mother, out of patience with coaxing, seized her hands and attempted to hold her forcibly. She screamed and resisted all the more, until blood made its appearance with the mucus from her throat. I said: "My little girl, I will have to give you up, and you will die and be carried and put into a hole in the ground, like your neighbor's little boy," (who had died of the disease only a few days before), and with that I rose from her side, but found, on moving away, that she held me by the skirt of my coat. From that time I had no further trouble with her.

So far, I have not failed in the realization that, when in timely attendance, I have, with this application by me, the diphtheritic exudation under perfect control. Yet I must confess that again and again great anxiety has been felt that it would fail. After the diptheritic patch is well covered by this compound no perceptible increase of its dimensions occurs. But when the

patch on one tonsil is under control another is very sure to appear upon the other, though I have not tried whether such an occurrence could be prevented by a simultaneous application to both. As every one familiar with the disease well knows, there may be no sign of the disease on the tonsil one day, but perhaps on a succeeding day, after a feverish, restless night, there it is in the morning, with the external glandular tumefaction well developed. When the disease extends up into the nasal cavities, the use of the camel's hair brush is impracticable, and I usually rely upon an injection of a liquid containing one fluid drachm of the solution of carbolic acid to seven fluid drachms of a saturated solution of chlorate of potassa.

A word as to prophylaxis. It is no uncommon thing for those suffering from diphtheria to spit or allow some of the diphtheritic matter from the throat to fall upon the floor or carpet. In a few hours it is dry; the broom of the early morn causes it to rise as a fine dust, which is drawn into the air passages of other members of the family, and thus lodges in the mucous crypts of the tonsil, there to vegetate in a congenial soil.

Editorial Department.

Periscope.

Respiration with Pauses.

Dr. Wm. O'Neill writes to the *Lancet*, October 30th, giving some cases simulating the Cheyne-Stokes respiration. He adds:—

What I wish more especially to say is, that the respiratory pause may be well marked, although the ascending and descending breathing acts may be more or less deficient, or even absent. Whether or not all those kinds of abnormal respiration which have a pause for their central phenomenon or symptom should be included under the category of Cheyne-Stokes respiration I am not prepared to say.

A lady who has suffered for several years from chronic bronchitis, emphysema of the lungs, great irregularity of the pulse, and hypertrophy, with dilatation of the right side of the heart, was attacked with an acute exacerbation of the chronic pulmonary affection in December of the past year. Œdema of the ankles, which was generally present, rapidly increased, and in a few days the dropsy extended to the waist. After this the patient was unable to lie down, and, although very drowsy, she was afraid to go to sleep, for the moment she closed her eyes in sleep the breathing stopped, and was only renewed on her waking, which was generally after an interval of from twenty to thirty seconds. The apnœal state, followed by a succession of inspirations, gradually increasing in force, and ending in the ordinary dyspnœa of the patient, were the phenomena present in this case. The ascending series of inspirations were present, but the descending were absent. It would appear that the moment the watchful and controlling care of the will was withdrawn from the respiration by sleep the breathing stopped, from some cause or other acting on the medulla oblongata, and which had been kept in abeyance during the patient's waking moments; and respiration was, I think, only renewed by the intensity of the stimulus of the *besoin de respirer*, which roused her to the urgent necessity of breathing. The immediate cause of the pauses was temporary, for as soon as the chest symptoms began to improve and the dropsy to subside, so did the pauses begin to pass away.

A case almost similar to the preceding came under my care in 1878. The pauses were perhaps longer and the series of inspirations more distressing. So frightened was this man at the stopping of his breathing, that for a few days before his death he kept his wife by his bedside in order to prevent him falling asleep.

Facial Neuralgia Cured by a New Surgical Operation.

The following case is from the *British Medical Journal*, by Dr. Aug. Brown. In April of this year, a lady, aged fifty-six, who had suffered many years from a most severe facial neuralgia, called upon me, and implored me to do something for her relief. I shall not readily forget the careworn expression of her face as she related to me the terrible nature of her sufferings. She told me that, for a period of upward of ten years she had endured the most fearful torture from constant attacks of neuralgia, which caused her to scream, and left her in an exhausted condition; and that, although she had incurred very considerable expense to obtain relief, she had failed to do so; and that the attacks were gradually increasing in violence, frequency, and extent. She also informed me that she had been an inpatient, for some weeks, in the London Hospital, under the care of Dr. Fenwick, and that she had left that institution no better. I need not enumerate the various medicines and remedies which had been tried in this case—ice, electricity, etc.—for all alike had failed; even subcutaneous injections, although at first mitigating the paroxysms, began to lose their influence. Impressed by the supplications of my patient, I promised to do something for her. After considering the case for a week, I resolved upon a plan which I carried out on May 11th, 1880. In this case, the

pain commenced in the mental nerve of the right side, just at its exit from the mental foramen; from this spot it ran backward to the front of the ear, then upward to the vertex, forward to the frontal nerve, down the right side of the face and neck to the arm, and backward to the scapula. On examining the mouth, I found the gum, above the starting-point of the pain, of a veined and congested appearance, thickened, and harder to the touch than the gum of the opposite side. The tongue was white and tremulous, and all the teeth had been extracted. Six years ago she had a portion of the alveolar process removed; the idea then being that the pain was produced by the pressure of a buried stump of a tooth; but the operation proved that this was not the case. Mr. Penny and Dr. Rowntree kindly assisted me with the operation. As soon as the chloroform took effect, I made an incision along the lower border of the jaw, and dissected up a flap till I reached the mental foramen. I then ran into the foramen a red-hot steel wire for a quarter of an inch or so, and thoroughly destroyed the nerve. On withdrawing the wire, the artery bled considerably, and I was obliged to plug the foramen. This plug was the cause of some amount of suppuration and delay in the healing of the wound. However, it came away in a few days in the discharges, and then the wound healed kindly, and my patient, from that time, has been entirely free from pain, and is now restored to health. Anything more satisfactory than the result of this operation I have never known. She is now able to take food without fear, to sleep without narcotics, her tongue has regained its color, and she now takes an interest in her household affairs. Much, lately, has been said and written about nerve-stretching; but the result of this operation proves that in the cautery we have another remedy upon which we may depend, and which, in many instances, may supersede nerve stretching; also one which possibly may be of great benefit in tetanus.

Antipyretic Properties of Hydroquinone and Resorcin.

Some time ago, says the Glasgow *Medical Journal* for November, Dr. L. Brieger showed that the above named bodies, together with pyrocatechin, all of which are isomeric with each other, possess antifermentative and toxic properties. As antifermentative and antipyretic properties usually go hand in hand, the author instituted a series of experiments, which all tend to show that hydroquinone and resorcin possess the power of lowering the temperature to a considerable extent. Pyrocatechin was not tried, being too powerful a poison. The patients experimented on suffered from pneumonia, typhoid fever, and the hectic fever of pulmonary phthisis. The dose of resorcin given varied from 1.5 to 3 grams. Its effect was to diminish all the febrile symptoms within an hour; in a few minutes giddiness was produced, followed by noises in the ears, acceleration of respiration, flushing of the face, profuse sweating, and a fall in the temperature amounting to 2–3° C. The pulse also became slower. The effects lasted but a short time; in 2–3 hours the temperature rose to its former point. The general condition of the patients was not improved; there was rather a disposition to collapse, which usually necessitated the administration of powerful stimulants. Hydroquinone acted equally promptly, but more powerfully, a smaller dose, 0.2–1.0 gram, sufficing to produce the same results. Much the same symptoms followed its use. It had the advantage, however, that the dose required to affect a fall in the temperature was, in most cases, so minute as to be accompanied by no deleterious action. It is also extremely soluble and non-irritant, and is thus well adapted for subcutaneous injection; these properties are the more important as we have, at present, no other remedy that can be used in that way, when patients suffering from very high fever can neither swallow nor retain rectal injections. The author has never seen it cause abscess when injected under the skin; he recommends a ten per cent. solution, of which he injects two Pravaz' syringefuls. This will reduce the temperature 2° C. within an hour, and the pulse rate by one-third; the antifebrile action is brief, however, and in one hour and a half pulse and temperature will usually be found to have again reached the fever point.

Some Important Uses of Amyl Nitrite.

The editor of the *Alienist and Neurologist* gives these uses of the amyl nitrite:—

Differential diagnosis of cerebral hyperæmia and anæmia.—Although it is not difficult to distinguish marked forms of these opposite cerebral states, yet there are instances where they sometimes present, even to the neurologist, so many negative evidences that any additional sign that may aid in clearing away the doubt is an actual gain in our means of diagnosis. This sign we have found in the action of nitrite of amyl inhalations, in the minimum doses. In the markedly anæmic, a single five-drop inhalation does not produce cephalalgia or any considerable amount of head uneasiness or suffusion of the face, while in the decidedly hyperæmic the sense of fullness of the head, and even of cephalic pain, is often exaggerated and very persistent even after one inhalation, the face also flushing more readily and extensively.

As a therapeutic agent in anæmia and imbecility.—The known property of this agent in quickening the cerebral circulation induced us to employ it by inhalation in the treatment of cerebral and spinal anæmia, and in the management of some imbecile patients. One little patient with very feeble head circulation, sluggish mental action and weakened power of control over the lower limbs, is now evidently being benefited by it conjoined with electricity and internal treatment. Two of our chronic aphasics are also on trial with it, conjoined with other medication, with a view of diminishing the area of possible arterial obstruction within the brain.

Chlorate of Potash in the Night Terrors of Children.

Dr. Harkin writes, in the Dublin *Medical Journal*, November, 1880:—

Young children from the first to the sixth year, particularly those sleeping in over-crowded

rooms, are subject to frequent attacks of screaming at night, with insensibility, and semi-convulsions, and somnambulism if not watched, and something approaching to the *petit mal*, due to the protracted inhalation of air deficient in oxygen and laden with carbonic acid and other morbid products—a persistence in this habit often leading to tubercle of the brain or lungs. For this condition I have always found the chlorate of potassium a sovereign remedy; and for the true convulsion and epileptic attacks of children it has proved not only curative, but, more important still, a true preventive. For the adult epileptic, although not so useful as the bromide, I have prescribed with great advantage this salt alone and in combination with the bromide.

Reviews and Book Notices.

NOTES ON CURRENT MEDICAL LITERATURE.

——The second volume of the Proceedings of the Philadelphia County Medical Society makes a volume of 130 pp., neatly printed and indexed. J. B. Lippincott, & Co.

——A very appreciative and well written biographical sketch of the late Professor James Aitken Meigs has appeared, from the pen of Dr. George Hamilton, of this city. The frontispiece is an excellent photograph of the subject of the memoir. Collins & Co., Philadelphia.

——Three useful little works on dietetics are among the recent issues. One is entitled "Food for the Invalid, the Convalescent, the Dyspeptic, and the Gouty." Macmillan & Co., pp. 150. It consists of an introduction by Dr. J. M. Fothergill, of London, twenty-eight pages in length, while the remainder of the book is made up of recipes for various dishes, collected by Dr. H. C. Wood. They do not offer much of novelty, but they are convenient for reference. The second work is by Dr. J. F. Edwards, of this State, and has for title "How a Person Threatened or Afflicted with Bright's Disease Ought to Live." Presley Blakiston, 12mo., pp. 87. Price 75 cents. It is written for the public, rather than the profession, but the precepts it contains will generally be accepted as judicious, and it was worth while to put them in popular form. The third work we refer to is Dr. J. W. Holland's "Diet for the Sick," 12mo, paper. Price 25 cents. John P. Morton & Co., Louisville. It contains, also, numerous receipts, and the special diet required in a number of particular diseases is detailed. The author is professor of materia medica in the University of Louisville, and writes as if he had bestowed careful study on the subject of which he treats.

BOOK NOTICES.

An Elementary Treatise on the Function of Vision and its Anomalies. By Dr. Giraud-Teulon. Translated from the second French edition by Lloyd Owen, F. R. C. S. I., etc. London, Bailliere, Tindall & Cox, 1880. 8vo. pp. 153.

We have here a remarkably lucid description of the physiology of the eye, its functional pathology, the treatment of the principal functional anomalies, the general hygiene of the organ, the symptoms which are of frequent occurrence in affections of the eye, and a concluding chapter on the nature and use of spectacles.

The work is printed and illustrated in an extremely neat manner, and the translator has given a version in excellent English.

Cutaneous and Venereal Memoranda. By Henry G. Piffard, M.D., and George Henry Fox, M.D. Second edition.

Ophthalmic and Otic Memoranda. By D. B. St. J. Roosa, M.D., and E. T. Ely, M.D. Revised edition. Wm. Wood & Co.

These little books appear to have found favor with students, and we can say for them that they are carefully prepared, by very competent hands, and, as far as they go, can be relied upon to give accurate information. For purposes of "refreshing the memory" they will be welcome, probably, to many beside students.

My Winter on the Nile. By Charles Dudley Warner. New edition. Boston, Houghton, Mifflin & Co.

For pleasant narrative—light, sparkling and withal instructive—commend us to this writer, whose other works have placed him in the front rank of American *literateurs*. The journey took place in 1876, but Egypt is ever the same, and the story of the traveler is as good as if it was last winter. The get-up of the volume is tasty, and we are sure it will have a wide popularity.

Walsh's Physician's Handy Ledger. By Ralph Walsh, M. D., Washington, D. C. Price $3.00.

In this volume Dr. Walsh has endeavored to reduce to its simplest terms the problem of bookkeeping for physicians. Each page is intended to exhibit the account of one patient for one year, showing the daily visits and the monthly total due. Columns are also inserted for credits and dates of payment. An index for names is at the beginning of the volume. A few lines for notes is at the bottom of each page. The arrangement is as handy a one as we have seen in any publication of the kind.

THE

Medical and Surgical Reporter,

A WEEKLY JOURNAL,

Issued every Saturday.

D. G. BRINTON, M.D., EDITOR.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	$5.00
Half-Yearly Compendium of Med. Science,	2.50
Reporter and Compendium, - - -	7.00
Physician's Daily Pocket Record, - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - -	8.25

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M.D.,
115 South Seventh Street,
PHILADELPHIA, PA.

CLOSING THE VOLUME.

So much of this number is given to the index, and the value of a book, especially a periodical, depends so greatly on its being thoroughly and exhaustively indexed, that no apologies are necessary for the brevity of the remaining contents.

Looking back at the expressions of hope for the prosperity of the country which we wrote a year ago—for the last number in 1879—we might almost style them predictions, so generally have they been accomplished. There is no reason to doubt but that the year to come will continue to be favorable to the development of our country at large, and we believe not less so to the interests of the profession. No one can question the intellectual and economical advances which the science of medicine has made in the last few years in the United States. He who runs may read it.

We close this volume and year with the wish that this advance may continue and increase, and that all our readers may be benefited by it, both in their professional and personal relations.

NOTES AND COMMENTS.

Action of Tulipine.

This is an alkaloid derived from the garden tulips. Prof. Ringer, *Practitioner*, October, 1880, gives its physiological action as follows:—

Tulipine differs almost entirely from the action of alkaloids derived from the plants belonging to the natural order amaryllidaceæ so far as I have examined.

Tulipine is a muscle poison, affecting the muscles like veratria. It is, however, weaker than veratria.

It paralyzes either the cord or the afferent nerves, or both; but probably it affects the afferent nerves.

Its action on the motor nerves, if any, is but slight.

It affects the heart of frogs like veratria.

It does not affect the pupil.

A New Physical Sign of Thoracic Aneurism.

Medical Press and Circular, October 27th, says: At a recent meeting of the Northumberland and Durham Medical Society, Dr. Drummond, of Newcastle, demonstrated a new physical sign which is likely to be of great diagnostic importance in thoracic aneurism. When a patient suffering from aneurism of the thoracic aorta is made to draw a long breath (inspire deeply), and then close the mouth and expire slowly through the nose, short, puffing expiratory sounds are heard—synchronous with the systole of the heart—on auscultation of the trachea. Dr. Drummond believes this phenomenon to be due to the sudden systolic expansion of the sac expelling air from the chest. He has found it absent in cases of aortic valvular disease simulating aneurism, but has not yet thoroughly worked out the significance of the sign.

Hypodermic Injections in Prurigo.

Dr. Fleischmann recommends an injection made of two grams of carbolic acid dissolved in one hundred of water. Half of a Pravaz's syringeful is first injected, and afterward a whole syringeful if intense itching persists. The injection should be practiced in the region which is the most constant seat of the prurigo, and should be repeated more or less frequently, according to the urgency of the case. In Dr. Fleischmann's cases from three to fifteen injections were required, one injection at least being practiced every second or third day.

On the Digestive Power of Figs.

In the *Comptes Rendu*, XCI, Prof. Bouchut speaks of some experiments he has made, going to show that the milky juice of the fig tree possesses a fermentative power of a digestive character. Having mixed some of it with a preparation from animal tissue, he found the latter well preserved at the end of a month.

We bring this fact into connection with a remarkable statement by Prof. Billroth, in his work on "Frauenkrankheiten." He tells of a case of cancer of the breast so excessively foul smelling that all his deodorizers failed, but on applying a poultice made of dried figs cooked in milk, the previously unbearable odor was entirely done away with.

Revival of Phlebotomy.

There are various indications that there will be a revival of venesection in the practice of the future. Several recent writers in the British journals advocate it. One of them says :—

I would here state I have deeply repented not bleeding of late years, in acute diseases, at the first; and I believe that if I had done so I should have been more successful in my practice; and am certain in my own mind, if the younger branches of the profession were to adopt this principle we should not hear of so many persons having pleuritic adhesions and heart disease after acute rheumatism. There is something of similar feeling in this country also.

Treatment of Painful Callus.

Prof. Gosselin, of Paris, observes that when the pains which have their seat in the callus of a fracture are of a neuralgic origin, we should treat them by blisters or cutaneous revulsives, and especially by the tincture of iodine. Hot or cold douches, or sulphurous douches, or frictions with a chloroform liniment may also be had recourse to. Finally, a roll-bandage with wadding is of undoubted utility, diminishing the pain sensibly by saving the limb from the little shocks which keep up the painful condition.

Persistent Priapism.

A case of this is recorded in the New Orleans *Medical and Surgical Journal*, October, 1880, by Dr. A. Maguire. The patient was fifty-six years of age, strong and vigorous, without any signs of leucocythemia. The attack lasted six weeks and disappeared spontaneously. None of the many remedies used had any effect. The pain was somewhat relieved by anodynes locally. The disease seemed self-limited, and without concurrent lesions. Such cases are rare, and as yet quite inexplicable.

Membranous Enteritis.

In the *Journal de Med. et Chir., Prat.*, Prof. Sée considers this affection as frequent, particularly in women subject to continued constipation. The fecal matters are found to contain matters resembling the white of an egg or scraps of vermicelli. Examination shows them to contain mucin, albumen and epithelium—no fibrin—demonstrating that the condition is not inflammatory; it is rather a form of entorrhœa. But it may become grave by inducing intestinal obstruction. Strong purgatives should not be given; mild laxatives, with proper diet and exercise, constitute the best treatment.

Correspondence.

Leucoderma Africanus.

ED. MED. AND SURG. REPORTER :—

Mr. Jordan Daniels, a gentleman of undeniable African descent, is about to become transformed to a white man. He is about forty-five years old, has resided in this latitude all his life. The transformation, or whitening process, has been going on the past eight years—until now he is two-thirds white under his clothes. There is a perceptible change taking place in the epidermis of the hands and face, and ere long all the pigment cells will disappear. The Ethiopian is certainly changing his skin. This man is never sick, has a large family of healthy, robust children. His family history is good, both parents being stout and robust, without any cachexia.

Mr. J. H. Thompson, M.D., of Goshen, New York, reported, October 26th, 1880, in your Journal of November 13th, 1880, a similar case. I report the above case as a matter of record, and hope some dermatologist will rise to an explanation of such phenomena, in a future number of your journal. M.D.

ED. MED. AND SURG. REPORTER :—

I notice a case of Leucoderma Africanus in your Journal of November 13th, last, reported by Dr. Thompson, of Goshen, New York. There is a case fully as remarkable, and greater in extent, now living in one of the rural wards of Philadelphia.

Sarah P., aged 37, widow, born in Haddonfield, New Jersey, has always been a perfectly healthy woman, and has never been bed-fast a day, except in her confinements. She is the mother of nine children, the oldest nineteen, and the youngest eight years. Her skin commenced to bleach just before the birth of the last child, and now she is as white as a Caucasian over two-thirds of her entire body. The discolor-

ation is not in spots, or islands, for the most part, but complete over large surfaces. The flexor surfaces of both arms are white, while on the dorsum of each arm there is a stripe of perfect black. The lower lip is white and the upper piebald. Neck white anteriorly, and largely so posteriorly. Both feet entirely white. There is a good line of demarcation almost everywhere between the two colors. The skin is perfectly healthy in appearance. Her hair is crisp and kinked and black, and her eyes distinctively of the colored race.

All of her children and relations, she says, are black, and without any appearance of change. This affection must be rare in the Northern States, at least, as but few medical men whom I have conversed with have ever seen a case.

H. Pursell, M.D.

Bristol, Pa., Dec. 3d, 1880.

Climate Cure—New Jersey Pines.

Ed. Med. and Surg. Reporter.

In compliance with your request for an account of the medical trip to Lakewood, in New Jersey, on the 23d, of November, I send you the following:—

We had a good number of representative physicians from Philadelphia, who made an inspection of the place, and agreed upon an expression of opinion which I shall give you below.

Lakewood is nearly midway between New York and Philadelphia, on the line of the New Jersey Southern, R.R., being about fifty miles from either city. It is a pretty little village, built upon undulating ground, and contains a permanent population of a little less than one thousand people. Its attractive features as a health resort are as follows:—

1st. The soil is a deep, dry sand, capable of the rapid absorption and percolation of water, and does not offer an evaporating surface for moisture more than a few hours after a heavy rain.

2d. The pine forests are extensive, and afford a shelter from cold winter winds, and thus the climate is moderated in a remarkable degree. The tract is far enough from the sea coast to secure immunity from damp, easterly sea breezes, having an intervening area of nine miles, which is chiefly covered with a fine growth, while it is equally protected from the severity of northerly and westerly winds, by even a wider range of woods, in these directions.

3d. The water is abundant, being supplied both by deep subsoil wells and by streams originating in "cedar springs," which are renowned for their purity.

4th. The accommodations for guests are unusually good. There are two commodious buildings, the "Laurel House," and the "Homestead," which are appropriated exclusively to guests, the appointments and management of which are superior to the average of hotels in such resorts. There are also a number of private cottages, where guests may be comfortably provided for.

The diseases for which such a locality is particularly serviceable will at once suggest themselves.

At the time of our visit there were patients with various forms of disease of the air passages, from acute laryngeal and pulmonary phthisis to the milder forms of bronchial irritation, all of whom bore testimony to the soothing influence of the climate; and some of them to the decidedly improving effect which they have experienced. There were others who were sent to Lakewood to rest from the wear and tear of business; and who found in the seclusion of the place, its quiet drives and walks through the dense woods, the means of mental as well as of bodily recuperation.

Altogether, our party were impressed with the desirableness of the place as a health resort in winter, as well as in summer. Its accessibility removes at once a laudable objection, urged by many invalids in the middle and eastern States, to leaving home, to wit: the expensiveness and fatigue of long travel, the distance from home and friends, and, in times of emergency, from their accustomed medical advisers. During protracted and wasting invalidism, as well as in the more acute and threatening forms of disease, to be within a few hours, by rail, of home, kindred and physician, has a moral effect which, of itself, is worth a great deal, and this feature of the place was especially impressive.

The tract embraces nineteen thousand acres, of which the village is the centre, resting upon the shore of a cedar water lake, which furnishes an additional attraction for fishing and boating.

The company who have purchased the tract intend to continue their improvements, in the way of building new roads, etc., till they have made it an extensive park, to be enjoyed by sufferers from all disorders which may be benefited by a sojourn in the midst of such surroundings. It is not to be cut up into town lots and avenues, for speculation, as so many resorts are, till they become too crowded for comfort, and till the suspicion is awakened in the public mind of the existence of insanitary methods of government. That the attention of the medical profession may be called to this locality, and the interest of physicians invoked in its behalf, is the object of the following resolutions, which were unanimously passed by the party:—

"*Resolved*, That we hail the establishment of this new winter resort for invalids as an important fact, which should be widely known to the medical fraternity.

"*Resolved*, That we recognize in the perfectly dry soil of this locality, in the balsamic aroma of the pine forest, and in the shelter from harsh winds afforded by its perennial foliage, qualities that are essential to a safe and comfortable resort for a large class of invalids who cannot safely reside in our eastern cities during the winter and spring months."

I may only add, in conclusion, that among the party were such men as Drs. Levis, C. H. Thomas, Albert H. Smith, Cohen, Ash, Baldwin, French, Watson, Kirkbride, Jr., Hays, Seyfert. Jennings, O'Neill and others, all of whom regretted your inability to join them, and none more so than your correspondent. Jos. Parrish, M.D.

Burlington, N. J., Dec. 3, 1880.

News and Miscellany.

A Tale of Two Cities.

The value of a correct diagnosis appears widely different in Philadelphia and in Baltimore. A week or so ago, a man named John Wyman died suddenly, in Philadelphia. It was in evidence that Dr. W. H. Kirk, an Eclectic or Indian physician, had prescribed for him a day or two before death, and when the man died Kirk gave a certificate stating that death had resulted from heart disease. Dr. Reese's post-mortem examination showed that acute pneumonia had caused death. The jury gave a verdict to that effect, and Coroner Powers announced that he would fine Dr. Kirk for issuing a certificate without knowing the cause of death.

On the other hand, last month, in Baltimore, a homœopathic practitioner, Dr. Thomas Shearer, attended a woman who had been hurt by falling down stairs. He said that she was suffering solely from heart disease, and treated her accordingly, but without helping her. Then she was placed in other doctors' hands, and they found that she had a spinal injury, of which she was speedily cured. Dr. Shearer sent in a bill for $100, and she refused to pay. There seems to be no doubt that his services had no good result; yet he claimed that the mistake was not due to incompetency or carelessness, and that he should be recompensed just the same. He took the ground that no physician can guard against an occasional incorrect diagnosis. What is curious is that he obtained judgment for $35.00 and costs.

Suppose the woman had died, and Shearer had certified to heart disease. Should he have been fined, or should he have been rewarded by being paid his bill?

The Very Latest Treatment of Diphtheria.

Diphtheria not only exists to an alarming extent in Brooklyn, but it is spreading every day, from twenty to twenty five new cases being the average daily report. The city authorities are said to be indifferent to an investigation of the causes of the disease or the discovery of a remedy, and in the meantime some of the poorer classes are resorting to a means of cure which, if not efficacious, is at least novel as far as the science of pathology in this country is concerned. This is no more or less than the offering up of prayers and the performance of ceremonies in honor of St. Blasius.

St. Blasius was a German, who lived in the third or fifth century, whose feast is celebrated on the 3d of February, and who, although not mentioned in the great ceremony of the Mass, has prayers in his honor in the rubrics. These prayers, which are very ancient, refer to him as one powerful by his intercession to assist those afflicted with throat troubles. The ceremony of invoking the Saint's succor is as follows: The priest who recites the prayers for the afflicted person holds two candles against his throat so as to form a cross, the lighted ends reaching up on either side of the chin, and while he is in this position reads the prayers which are believed by the faithful to effect a cure.

We presume no intelligent Roman Catholic approves of this superstition, and as standing in the way of sensible and efficient measures, all should distinctly oppose it.

A Progressing Society.

A meeting of the Montgomery County, Pa., Medical Society was held lately, with Dr. Samuel Wolfe, of Skippackville, presiding. Dr. Mary Stinson, of Norristown; Dr. Alice Bennett, chief of the female department at the Asylum, Dr. Annie Kugler, her assistant, and Dr. Chase, chief of the male department, were unanimously elected members. The request of the Philadelphia Obstetrical Society to take action to influence the members of the Legislature from this county to secure the passage of a law "which would protect the public in its confidential relations with the physicians, as it is now protected in its relations with the lawyer and priest," was referred to a committee consisting of Drs. Hiram Corson, J. K. Reid and David Schrack. Dr. J. K. Weaver read a selected article on "Long Continued Lactation."

The Way of Transgressors.

Last week, in the case of Dr. John Buchanan, formerly Dean of the Eclectic Medical College, Pine street, above Fourth, Philadelphia, and of the American University of Pennsylvania, charged with conspiracy to defraud the United States, a fine of $500 was imposed by Judge Butler, in the United States District Court. Added to this were the costs of the prosecution, and the prisoner will also have to undergo ten months' imprisonment. M. V. Chapman, in the same case, was fined $500 and costs and sentenced to a year and ten months' imprisonment.

Dr. Charles Earl, convicted of malpractice, which resulted fatally, was sentenced, in Chicago, recently, to five years' imprisonment in the penitentiary.

Little by little, such characters are being weeded out of the profession.

The Walnut Hill Asylum.

The Walnut Hill Inebriate Asylum at Hartford, Conn., has been reorganized, and is now opened for the reception of patients on the family and home system. No institution in the country has more legal power and capacity to both restrain and manage its inmates, and under the charge of Dr. T. D. Crothers, so well known in this special field, we may confidently look for more practical results and much excellent work.

Personal.

—Herman C. Evarts, M.D., for the past three years Assistant Physician at the Friends' Asylum, Frankford, Philadelphia, has recently been appointed Assistant Medical Superintendent to the New York City Asylum for Insane, Blackwell's Island.

Correction.

Dr. Landesberg wishes to correct the prescription given in his article, on p. 397 of the REPORTER. The dose should be a *teaspoonful*, not a tablespoonful.

Items.

—At a late meeting of the Academy of Natural Science, in this city, Dr. Nolan called attention to a series of exquisite photographs of microscopic sections of the nervous system, prepared and presented to the library by Dr. John J. Mason, of Newport, R. I. They are printed in ink by the autotype process, from negatives taken by the author, and, in clearness and definition, leave little or nothing to be desired.

—Singular, how easy it is to surpass doctors in professional knowledge. The editor of the London *Truth*, Mr. Labouchere, says: "About two months ago I arrived at Milan, from the Lake of Como. I felt the symptoms of malaria, and instead of sending for a doctor, shut myself up in my bedroom for two days and two nights, during which time my only nourishment was lemonade. This *régimen* entirely cured me. Were those who catch any malarial fever in Italy to pursue the same course they would find it worth all the prescriptions the doctors ever wrote."

OBITUARY NOTICES.

—We record with regret the death of Assistant Surgeon Glazier, U. S. A., at Key West, Florida, on December 12th, of yellow fever. He was a most promising member of the medical staff, and fell in the line of duty, a martyr to the demands of his position.

—Dr. Wilbur F. Sandford, a well-known physician in Brooklyn, died December 12th, from diphtheria. On the 9th he performed tracheotomy on a little girl sick with diphtheria. The false membrane filled the tube, and the child would have choked to death had not Dr. Sandford put the end of it in his mouth and cleared it of the obstruction, thus allowing the child to breathe. The operation did not prove successful and the doctor himself contracted the disease.

—Dr. G. C. Terhune, a leading physician of Hackensack, died very suddenly November 27th. He was returning home from a professional call at seven o'clock, A.M., and in walking along Main street said to a gentleman who was with him, "I feel faint." He then fell over backward and was dead in a few minutes. Dr. Terhune was a surgeon in the army, and was a leading member of the medical profession in Bergen county.

—Dr. Isaac A. Nichols died in Newark on November 29th, aged fifty-two years. He was the city's Health Physician for over twenty years, and had a large private practice. He was a graduate of the College of Physicians and Surgeons.

QUERIES AND REPLIES.

MR. EDITOR:—Be kind enough to inform me in regard to the following:—

You published in the MEDICAL AND SURGICAL REPORTER for October 30th, 1880, the following law: An act entitled, an Act to Regulate the Licensing of Physicians and Surgeons in New York. Does this law require the doctors of the city of Brooklyn, or physicians who intend practicing there, to comply with the requirements as published? DR. F. O. G.

Ans.—We understand that it does.

MR. EDITOR:—If W. S. J. will give Dr. Stump Forwood's prescription for vomiting in pregnancy a trial, I think he will give his patient relief—

℞. Rad. columbo,
Rad. zingibir., aa 3ss
Fol. sennæ, 3j
Aquæ bullient., Oj.
Infusion.

SIG.—Take a wineglassful before each meal.

H. N. BURR, M.D.

MR. EDITOR:—W. S. I. wishes a remedy for flatulent dyspepsia. Either of the following I have found satisfactory in such cases:—

℞. Potass. chlor.,
Sodæ bicarb., aa 3iiss
Rhei pulv., 3ss
Capsici pulv., gr.iv
Ol. sassafras, gtt.ij. M.

SIG.—Dissolve in half pint of water, and give tablespoonful *immediately* after each meal.

℞. Bismuth subnit., 3v
Sodæ bicarb., 3ij
Pulv. carbo lig., 3iv
Rhei. pulv., gr.xxiv
Capsici pulv., gr.ij
Ol. menth. pip., gtt.ij. M
Ft. pulv. xij.

SIG.—One after each meal, in a little water.

Baltimore. N. W. L.

ED. MED. AND SURG. REPORTER.—Quinine may be rendered tasteless by giving it with powdered slippery elm bark. Take about five grains of the bark and mix with about half a tablespoonful of water, stirring till the mass is thoroughly mucilaginous. Then mix in the dose of quinine, and give it to the patient, following it with a swallow of water. The bitter is barely perceptible. I have never seen this method in print.

L. B. TUCKERMAN, M.D.

Austinburg, Ashtabula Co., O., Dec. 4th, 1880.

Dr. W. S. B., of Pa. Your inquiries about pilocarpine will be answered in detail in an early number, as to reply properly would require more space than we can spare in this number.

MARRIAGES.

LOWENGRUND—VENDIG.—In this city, on the 8th instant, at the residence of the bride's parents, by the Rev. George Jacobs, Dr. Lee Lowengrund and Miss Helen Vendig, daughter of Samuel Vendig.

WALDRON—MILLER.—At St. Thomas' Church, New Windsor, New York, November 23d, by Rev. Haslett McKim, Dr. Henry A. Waldron, and Miss E. E. Miller, daughter of the late John Craig Miller, of Philadelphia.

WOOD—WICK—On Thanksgiving Day, Nov. 25th, 1880 by the Rev. J. Matcer, D.D., Sligo, Pa., George H. Wood, M.D., and Miss Mary E., only daughter of the late Dr. H. M. and Mrs. Mary F. Wick, New Bethlehem, Clarion Co., Pa.

INDEX.

Abdomen, enlargement of, 98.
Abnormalities of the colon and omentum as causes of reflex psychoses, 475.
Abortion, belladonna in, 171.
Abortive treatment of boils, 348, 414.
Abscess; bursting in peritoneal cavity, 67; of the spleen, 211.
Accidents apt to occur during aspiration of pleuritic effusions, 523.
Acid reaction in animal tissue, 152.
Aconitia in prolonged neuralgia, 397.
Action; of collodion on temperature, 195; of erythrophleine, 372; of quinine, etc., 195; of tulipine, 556.
Acupuncture, 167.
Acute; alcoholism, treatment of, 392; hydrargyrism, 424; laryngitis in young children. 387.
Advantages of exclusively vegetable diet for children, 371.
Affections of the eye from pertussis, 248.
Ague, faradizing the spleen in, 481.
Albuminuria, 218.
Alcohol; and animal heat, 261; in the blood, 547.
Alcoholism, 392.
Alkaloid. jaborine, 459.
Alopecia areata, 82.
Altitude in pulmonary disease, 320.
Amaurosis, epileptic, 128.
Amenorrhœa, 334.
American; academy of medicine. 260, 330; association for cure of inebriates, 330; dental association. 142, 198; public health association, 351, 374, 548.
Ametropia of keratoconus, glasses for, 173.
Ammonia salts in diabetes, 408.
Amputation at knee joint, 350.
Amyl nitrite, some uses of, 554.
Anæsthesia by ethyl bromide, 114.
Anæsthetic for children, chloral as, 481.
Anæsthetics; in labor, 430; in 1651, 264; two new, 504.
Anal fissure, 303.
Aneurism; simulation of, 262; of the arch of the aorta, 253.
Aneurisms; 11; digital compression of, 153.
Animal tissue, acid reaction in, 152.
Ante-mortem rigor mortis, 128.
Antiphlogistic touch in erysipelas, 289.
Antipyretic, properties of hydroquinone and resorcin, 554.
Antiseptic; method in cranio-cerebral surgery, 321; midwifery, 472; treatment of gunshot wound of knee, 217; inflation, 543.
Anti-vaccination, 196.
Anti-vivisection; 373; in England, 110.
Anti-vivisectionists; 242.
Antrum, preservation of malar bone in operations on, 331.
Anus; absence of, 299; imperforate, 482.
Apparent death as a result of asphyxia, 218.
Arciform fibres of the medulla oblongata, 150.
Argenti nitras et opii, 285.
Arsenic; in chorea, 19; in fabrics, test for, 371.
Arthurs, Addison, death of, 352
Ascaris lumbricoides, extraordinary, 107.
Asthma, iodide of ethyl in, 102, 391.
Asthmatic bronchitis, 323.
Astigmatism, mixed, caused by sucking the eye, 82.
Astrological pathology, 132.
Atmosphere of Leadville, 18.
Atresia of vagina, congenital, 148.
Atropia; action of, 195; in chloroform narcosis, 545.
Autopsies, data of, 188.
Axilla, malignant tumor of. 130.

Bacon, Alvan, death of, 526.
Barber's itch, 217.
Bath treatment of fever, 283.
Baths of blood, 437.
Bathing after meals, 237.
Batley's sedative, 110.
Batteries, making, 197.
Beardsley, L. N., death of, 528.
Beck, F. D. death of, 528.
Beef; and bitters, 482; tea and its value, 349.
Belladonna; in abortion and dysentery, 171; disease. 265; for horses, 440; poisoning treated by chloral, 124.
Benzoate of soda; 251; in pertussis, 369, 538; in phthisis, 429; in scarlet fever, 277.
Bernard, memorial to Prof., 197.
Bismuth, phosphate of, 38.
Blood; alcohol in the, 547; in fever, 64; transfusion of, 322.
Bloodless; operations, 210; excision of the mammary gland, 504.
Bogus; colleges wiped out, 329; diplomas in Boston, 352.
Boils; of external ear, 196; to abort, 348, 414.
Bone drainage tubes, 547.
Bony tumor in muscle, 173.
"Bonwill's method," dangers of, 480.
Bowel, ulceration of, 123.
Bradley, S. M., death of, 44.
Brain function obliterated and renewal of, 388.
Breast, schirrhus of, 474.
Bright's disease; 319, 382, 401; fuchsin in, 453.
British Medical Association, 294, 318, 342, 361.
Broca, monument to Prof., 198.
Bromide of potassium; as a therapeutic agent, 284; spray in pertussis, 218; in vesical catarrh, 412.
Bromides, disguising taste of, 369.
Bronchitis, 67.
Bronchotomy; 515; infra-hyoid, 159.
Buchanan captured, 264, 462.
Burning of the Minnesota insane asylum, 484.
Burns, 6, 260, 327.

Canada Medical Association, 373.
Cancer; cure, 260; chian turpentine in, 414, 430; diet in, 101; hemlock in, 257; in stomach, 107.

Carbolic acid ; in lupus, 278 ; perfumed, 480.
Carbolized camphor in diphtheria, 218, 241.
Carcinoma ; of cervix uteri, 208 ; of uterus, 446 ; of liver, 174.
Cardiac sedative, a new, 106.
Care of the teeth, 431.
Cases with accidental and rare complications, 67.
Cataract ; extraction, 212 ; suction for, 463.
Catarrh, nasal, 540.
Catarrhal ; gland fever, 421 ; conjunctivitis, 468.
Cause and prevention of phthisis, 304.
Causes of diphtheria and typhoid, 481.
Cavendish, 418.
Cayman's oil and turtle's oil, as substitutes for cod-liver oil, in consumption, 326.
Cervix uteri; carcinoma of, 208; laceration of, 209.
Chamber's, Montgomery, death of, 396.
Charcot, an officer of the Legion of Honor, 207.
Chartreuse liquor, 528.
Cheap galvanic battery, 219.
Chian turpentine in cancer, 414, 430.
Children ; acute laryngitis in, 387 ; foreign bodies in œsophagus of, 107 ; chloral in operations on, 454; night terrors of, 554; summer diseases of, 50, 111, 155 ; worms in, 413.
Chloral ; as an anæsthetic for children, 481 ; in belladonna poisoning, 124 ; in operations on children, 454 ; in phthisis, 349 ; in strychnia poisoning, 415.
Chlorate ; of cromium, 88 ; of potash ; in hemorrhagic diathesis, 541 ; in night terrors of children, 554.
Chloride of calcium in phthisis, 59.
Chloroform ; in puerperal convulsions, 233 ; in tetanus, 172; narcosis, atropia in, 545; watching the pulse under, 211.
Chlorosis; 171 ; mixture for, 545.
Cholera infantum ; 50 ; oxalate of cerium in, 407.
Cholera ; in India, 286 ; in Russia, 264, 374.
Cholotomy, 375.
Chorea, arsenic in, 19.
Chronic granulations from virus of purulent ophthalmia, 468.
Chrysophanic acid in skin diseases, 452.
Churchill's tincture of iodine, 462.
Cicatrix of filtration theory, 363.
Cirrhosis of liver in an imbecile, 460.
Clay's new cancer cure, 260.
Climate cure, 558.
Coca, 124.
Codeia, 231.
Cod-liver oil ; and iodoform, 105 ; tasteless, 328.
Cold ; a cause of deafness, 406 ; pack, in pneumonic fever, 426; baths, in cerebral rheumatism, 473.
Collection of data of autopsies, 188.
Color-blindness, 238.
Colors, sense of, 436.
Complicated diagnosis, 197.
Conjunctivitis; catarrhal, 468; from chloral, 370.
Consciousness, 328, 460.
Conservative treatment of sympathetic ophthalmia, 546.
Constant current; in disease of the internal ear, 437; in intestinal occlusion, 282.
Constipation, infantile, 30.
Constituents of tobacco smoke, 152.
Consumptives ; resort for, 481 ; South America for, 282.
Contagium of gonorrhæa, 503.
Convulsions ; epileptic, etc., 385 ; nitrite of amyl in, 344.
Coppedge, C. P., obituary of, 462.
Corns, remedy for, 63.
Corpse, property right in, 506.
Crane, Lyman Mark, death of, 528.
Creasote in phthisis, 434.
Crede ; method among Kiowa Indians, 124 ; on nerve stretching, 474.
Crematory process, 437.
Cresolene in pertussis, 370.
Croup ; 539 ; diphtheritic, 536.
Curability of acute phthisis, 319.
Curacoa, formula for, 176, 462.
Cure ; of grave case of hysteria by simulating the operation of spaying, 503; of facial neuralgia, 553.
Curette, nasal and ear, 18.
Curtains or no curtains, 97.
Cyanide of mercury test for sugar in urine, 272.
Cystitis, 327.

Da Costa's medical diagnosis, 418.
Danger of combining anodynes, 369.
Dangers ; from steel pens, 437 ; of "Bonwill's Method" of anæsthesia, 480.
Dangerous imposition, 438.
Deafness ; from cold, 406 ; from syphilis, 510.
Death ; signs of, 93 ; in the pot, 504 ; to unqualified practitioners, 220.
Decalcified bone drainage tubes, 547.
Delpech, Prof., death of, 374.
Dentifrice, 163.
Detection ; of strychnia in exhumed bodies, 191 ; of organisms in water, 545.
De Young, Philip, death of, 242.
Diabetes ; mellitus, etiology of, 370 ; salts of ammonia in, 408 ; insipidus, 513.
Diabetic urine unchanged, 538.
Diagnosis, of intoxication, 372.
Diarrhœa ; kumyss in, 414 ; of children, 111 ; oxide of zinc in, 281 ; phosphate of zinc in, 150.
Diet in cancer, 101.
Difference in the estimate of longevity, 484.
Digestion in plants, 435.
Digestive power of figs, 557.
Digitalis and alcohol in pneumonia, 281.
Digitaline, action of, 195.
Diploma traffic, 20, 109, 175, 394.
Diphtheria ; 129, 166, 305, 445, 528 ; carbolized camphor in, 241 ; causes of, 481 ; in Johnstown, 374 ; salt a prophylactic of, 371 ; thymic acid for, 150 ; latest treatment of, 559 ; local treatment of, 551 ; pilocarpin in, 540.
Diphtheritic croup, 536.
Diseases ; of the uveal tract, 238 ; of workmen in St. Gothard tunnel, 439.
Disguising taste of bromides, 369.
Dislocation ; at the wrist, 191 ; of radius and ulna, with fracture, 71.
Diuretic remedies, 319.
Diuretics, uncertain action of, 42.
Drainage of lands, 329.
Drunkenness and suicides, 86.
Dublin unhealthy, 440.
Duboisia, 27.
Duval, Prof. M., appointment of, 289.
Dysentery; 155 ; belladonna in, 171.
Dysmenorrhœa, 334.
Dyspepsia, nux vomica in, 350.

Ear, foreign bodies in, 108.
Early excision in rectal cancer, 356.
Easy test for arsenic in fabrics, 371.
Eclampsia, 102, 419.
Eczema; of face after neuralgia, 145; salicylic acid in, 85; treatment of chronic, 394.
Editorials—
Ante Natal or Race Education, 16.
Household Education, 39.
Scholastic Education, 62.
Business Education, 84.
Sex, in Education, 104.
Legality of Sanitary Measures, 126.
Registration of Disease, 148.
Measures against Trichinosis, 149.
Protection from Venereal Diseases, 170.
Efforts to Obtain Medical Statistics, 193.
Medical Education, 215.
The Practice of Incineration of Corpses, 216.
The Inviolability of Professional Communications, 236.
Natural History and Self-Limitation of Diseases, 259.
The Late Meeting of the American Dermatological Association, 280.
The Increase of Inebriety, 302.
How the Metric System has been Getting On, 325.
Women as Delegates, and Women's Brains, 347.
Who's to Blame for the Bogus Diploma Business, 368.
For and Against Therapeutical Novelties, 390.
Questions about Vaccination, 410.
Privileged Communications to Physicians, 411.
The Purposes of a Scientific Society, 433.
Trichinosis and its Sequelæ, 457.
The Value of Diplomas, 458.
Is Medicine a Science or an Art? 477.
Malignant Charbon, 478.
"Maisons De Sante," in Cities, 479.
What Determines the Sex of Children? 501.
What to Do When at a Loss, 522.
New Experiments in Hypnotism, 544.
Closing the Volume, 556.
Effect on heart of preceding inhibition, 128.
Effects; of an exclusive meat diet, 475; of lightning stroke on the animal organism, 452.
Elastic; bandage in elephantiasis, 519; ligature in anal fistula, 407.
Electricity, influence of, on bacteria, 64.
Elephantiasis; 519; in the Samoan Islands, 459.
Elixir chloroformi compositus, 366.
Embolism, 540.
Emphysema, 293.
Enemata, nutritive, 129.
Endometritis; 334; new method of treating, 344.
Enlargement of the Reporter, 480.
Enteritis, membranous, 557.
Ephelides of pregnancy, 328.
Epidemic cerebro-spinal meningitis, 529.
Epidemics, etc., 480.
Epilepsy; 10; and crime, 127; from foreign body in ear, 305; syphilitic, 233.
Epileptic; amaurosis, 128; convulsions, 385.
Epizooty, 462.
Epizootic disease, 370.
Epsom salts, to disguise the taste of, 52.
Ergotine, 172.
Ergot; for fibroid of womb, 512; in pharyngitis, 217; poisoning, 298; in the intestinal hemorrhage of typhoid fever, 546.
Errors of diagnosis in eye disease, 538.
Erysipelas; 85, 167, 290; from tattooing, 440.
Erythrophleine; 106; action of, 372.
Estimation of size of stone in the bladder, 453.
Ethnological phenomenon, 168.
Ethyl bromide, anæsthesia, by, 114.
Etiology of diabetes mellitus, 370.
Eucalyptus, oil of, 283.
Eustachian tubes, normal condition of, 129.
Euonymin in pseudo-membranous colitis, 326.
Evolution of consciousness, 157.
Excessive foot sweating, 369.
Excision; of the knee and of the hip, 297; of the knee joint for gelatinous arthritis, 470.
Excusable mistake, 525.
Experiments with a decapitated head, 524.
External biliary fistulæ, 484.
Extirpation of rectum without destroying the sphincter ani, 507.
Extremes of temperature, 413.
Eye diseases; in pregnancy, 144; errors of diagnosis in, 538.
Eyes, weak, Schell on, 53.

Facial neuralgia cured by surgical operation, 553.
Famine in Asia Minor, 242.
Faradizing the spleen in ague, 481.
Fasting, prolonged, 131.
Fat, non-conductivity of, 174, 219.
Fecundity, extraordinary, 66.
Feet; bad odor of, 241, 364, 503; sweating of, 241, 364, 503.
Female delegates to the international medical congress, 370.
Femur, fracture of neck of, 306.
Fergusson and conservative surgery, 297.
Fever, bath treatment of, 283.
Fevers; in Rio Janeiro, 330; quinine in 355.
Fibroid; recurrent, 19; uterine tumors, 441.
Fibula, fracture of, 447.
Figs, digestive power of, 557.
Filaria sanguinis hominis, filaria disease, 269.
Fistulæ; 121; external biliary, 484; in ano, elastic ligature in, 407.
Flatulence, glycerine in, 101.
Flatulent dyspepsia, 506, 558.
Flaying the vocal cords, 398.
Foot; amputation, 470; binding in China, 360.
Foreign bodies; in the ear, 108; in the air passages, 515; epilepsy from, 305; in the œsophagus of children, 107; in the rectum, 414.
Four years for medical students, 327.
Fracture; of neck of femur, 306; of patella, 270, 372.
Frost bite, nature and treatment of, 6.
Fuchsin in Bright's disease, 453.
Fungoid condition of the endometrium, 335.

Galvanic battery, to make a cheap, 94
Gangrene of scrotum and penis, 174.
Gastritis, 165.
Gastrotomy, 404, 541.
Generalized vaccinal eruptions, 194.
Germany, letter from, 108.
Gilbert, W. K., death of, 22.
Glaucoma, 362.
Glazier, — death of, 560.
Gleanings from practice, 161.
Glycerine in flatulence, acidity and pyrosis, 101.

Goitre and pregnancy, 516.
Gonorrhœa; 40, 303; contagium of, 503.
Granular lids; treatment of, 132; from virus, etc., 469.
Granulations in pharynx and larynx, 127.
Growing; fat on air and water, 88; importance of veterinary medicine, 484.
Gunshot wound of base of brain, 41.

Habit of making believe, 152.
Hæmophilia, venesection in, 453.
Handy method of resuscitating neonati, 524.
Hard rubber pessaries. 526.
Hay asthma, Turkish bath in, 372.
Headache, in school children, 480.
Headaches, and their treatment, 386.
Health rate of foreign cities, 503.
Healthy place, 461.
Heart disease; milk diet in, 371; tuberculosis of, 195.
Hemianesthesia, 542.
Hemicrania, pills in, 545.
Hemiopia, 517.
Hemlock, in cancer, 257.
Hemorrhagic diathesis, chlorate of potash in, 541.
Hemorrhoids, 120.
Hepatitis, 290.
Herpes, 303.
Higher mortality in valleys, 482.
Hills, R. M., death of, 66.
Hip-joint, operation, 400.
Hoffman, appointment of Prof. A. W., 213.
Holmes, on spelling reform, 329.
Hospital day in Philadelphia, 352.
Hospital Reports—
Bellevue Hospital—
Service of Austin Flint, 22, 52, 426.
Service of Dr. Polk, 272.
Service of Wm. Thomson, 314, 381, 401.
College of Physicians and Surgeons, N. Y., 30.
Service of Dr. F. N. Otis, 184.
Service of Dr. Jacobi, 336.
Hartford, Connecticut, Hospital, 57.
Jefferson Medical College Hospital—
Service of Dr. Van Valzah, 10, 291.
Louisville City Hospital—
Service of M. F. Coomes, 73.
Service of J. M. Matthews, 120.
Mercy Hospital, Louisville, 164.
New Haven (Conn.) General Hospital, 230.
Pennsylvania Hospital—
Service of R. J. Levis. 447.
Service of J. H. Hutchinson, 512.
Service of T. G. Morton, 537.
St. Mary's Hospital—
Service of H. A. Wilson, 468.
Hospital of the University of Pennsylvania—
Service of Dr. Ashhurst, 142, 470.
Service of Dr. Goodell, 98, 208.
Hospitals and religious liberty, 528.
How; long does gonorrhœal virus retain its potency on dry and inanimate surfaces? 483; shall we interpret the deviations of the head of the incurable epileptic? 442; to feed the sick, 257; the finest wines are made, 154.
Hutchinson, J. H., on general hyperostosis, 358.
Hydrocele, radical cure of, 82.
Hydrargism, acute, 424.
Hydroquinoine, antipyretic properties of, 554.
Hygienic; Congress, 43; screen, 240; treatment of varicocele. 504.
Hyoscyamine, uses of, 123.
Hyperostosis, general, 358.
Hypodermic; doses of morphia, 327; injections in prurigo, 556.
Hypophosphorous acid, 524.
Hyposcleral sclerotomy, 363.
Hyposulphite of soda in diphtheria, 445.
Hysteria, whipping in, 195.
Hysterical convulsions, 385.

Idiots, marriage of, 504.
Ignipunctnre for granulations in pharynx and larynx, 127.
Immediate suture of divided nerves, 322.
Imperforate anus, 337, 482.
Incoercible vomiting of pregnancy, 196.
Incontinence of urine, 303.
Index rerum, 164.
India, cholera in, 286.
Inebriety, studies in, 287.
Infant mortality, 440.
Infanticide, 220.
Infantile constipation, 30.
Infection; quality of, 435; of tuberculosis, 172.
Inflammations of the urethral membrane, 243.
Influence; of change of position of the body on its temperature, 436; of music on the circulation of the blood, 499; of injuries, etc., of the nervous system on nutrition, 361; of race on insanity, 481; of light on nutrition, 542.
Infra-hyoid bronchotomy, 159.
Injurious effects of salicylic acid, 438.
Inoculability of cancer, 330.
Insanity; from sunstroke, 418; influence of race on, 481.
Insolation, 252.
Interesting pulmonary case, 482.
International; Congress of Hygiene, 440; health statistics, 436; Laryngological Congress, 373; Otological Congress, 417; Sanitary Conference, 461.
Intoxicants, test of, 240.
Intoxication, diagnosis of, 372.
Intra-uterine injection; of iodide in post-partum hemorrhage, 278; of antiseptic solutions, 480.
Intravenous injection of milk, 322.
Iodide; of ethyl in asthma, 102, 391; of potassium; poisoning, 195; in typhoid fever, 345.
Iodine; liniment, 164; manufacture in South America, 65.
Iodized; cotton, 393; glycerine, 391.
Iodoform, uses of, 473.
Iowa State University, 461.
Iris, congenital band of, 30.
Iritis, diagnosis and treatment of, 199.
Is shampooing advisable, 437, 505.
Itching of the scalp, 242.

Jaborandi in mumps, 303.
Japan; medical profession in, 132; patent medicines in, 87.
Japanese inundation fever, 64.
Jefferson Medical College, 527.
Jerusalem as a winter resort, 264.

Kava kava in painful micturition, 285.
Keyser, P. D., ophthalmological notes, 27.
Klebs, Prof., resignation of, 285.

Knee joint; amputation at, 350; excision of, 470.
Kneeling posture in parturition, 525.
Kumyss in diarrhœa, 414.

Labor; with albuminuria, 143; removal of a uterine tumor during, 190; obstructed by repaired perineum, 388; anæsthetics in, 430; quinine as inducing, 435; non-interference in, 450.
Laceration; of cervix, 100; of perineum, 42.
Lactucarium as a sedative, 393.
Large doses of morphia hypodermically, 395.
Largest man in America, 506.
Latest treatment of diphtheria, 559.
Lautenbach, B. F., obituary resolutions on, 110.
Lead poisoning, 254.
Leadville, atmosphere of, 18.
Leeches, how to get to fasten, 306.
Lepra, rubber in, 395.
Leprosy in Sandwich Islands, 329.
Leptothrix, 28.
Leucæmia, priapism in, 87.
Leucoderma Africanus, 439, 557.
Lictus morphiæ, 231.
Light, influence of on nutrition, 512.
Lightning stroke, effects of, 452.
Lithotrity at a single sitting, 321.
Living skeleton, 527.
Local treatment of diphtheria, 551.
Louisiana lepers, the, 417.
Lumbago, 540.
Lupus, carbolic acid in, 278.

Making batteries, 197.
Malaria in New England, 374.
Malignant; syphilis, 256; tumor of the mammary gland, bloodless excision of, 504.
Mammitis, 335.
Marine Hospital Service, changes, etc., in, 43, 351, 483.
McCay, R. B., death of, 528.
McCrea, Jas. A., death of, 22.
McMichael, Josiah, death of, 198.
Meat; bread, 40; diet, effect of, 475.
Medical Societies—
  Baltimore Academy of Medicine, 404.
  Baltimore Medical and Surgical Society, 539.
  Clinical Society of Maryland, 537.
  College of Physicians of Philadelphia, 358.
  Biological, etc., section of Academy of Natural Science, 449.
  Medico-legal Society, 76, 338.
  Union meeting of Lancaster and other counties, 31.
  Union Medical Association, 219.
  Rhode Island Medical Society, 78.
  Tri-States Medical Society, 496, 515.
Medical; law of New York, 395; legislation, some effects of, 308; profession in Japan, 132; schoolmaster abroad, 374; use of Burgundy wines, 472.
Medico-pharmaceutical abscess, 76.
Melobiah, death of, 396.
Membranous enteritis, 557.
Memorial to Prof. Bernard, 197.
Meningeal artery, ligature of middle, 14.
Menstruation during pregnancy, 408.
Menorrhagia and metrorrhagia, 334.
Metallo-therapy, 60.
Metritis, 451.
Micturition, painful, kava-kava in, 285.
Midwifery; conservative, 65; antiseptic, 472.
Milbet, H. B., obituary of, 176.
Milk; injection of, 322; diet, in heart disease, 371; sickness, 299, 416; transmitting tuberculosis, 412.
Mischievous effects which may arise from the Listerian precautions in abdominal section, 190.
Modern scientific medicine, 294.
Monstrosity, 87.
Monument to Prof. Broca, 198.
Morphia hypodermically in large doses, 239, 395.
Mortality of physicians, 437.
Motor nerves of the eye, their origin, 546.
Mucilage, a good, 164.
Multiple papillary tumors of the labial, buccal, and glossal mucous membrane, 323.
Mumps, jaborandi in, 303.
Muriate of ammonia mixture, 165.
Muscle, bony tumor in, 173.
Music and the circulation of the blood, 499.
Mutual Aid Association, of Philadelphia, 307.
Myomata, 305.

Nævus; 304; removal of, 328.
Napheys' Therapeutics, 327.
Nasal catarrh, 540.
Nascent iodide of mercury, 42.
National Temperance Almanac, 475.
Navel, new dressing for, 305.
Negro gradually turning white, 373.
Nepenthe, 418.
Nephritic colic, 451.
Nephritis, chronic interstitial, 534.
Nephro-lithotomy, 518.
Nerve; grafting, 392; stretching, 474.
Nerves of the eye, origin of motor, 546.
Nettle tea in urticaria, 414.
Neuralgia; of first branch of fifth pair cured by aconitia, 397; facial, cured by surgical operation, 553.
New; classification of skin diseases, 459; dressing for the navel, 305; instruments, 286; medical colleges, 440; method of disposing of the umbilical cord, 393; operation for prolapsus uteri, 304; physical sign of thoracic aneurism, 556.
Newton; John Jr., death of, 396; L. V., death of, 198.
New York Medical Law, 374, 395, 418.
Nichols, I. A., death of, 560.
Night; medical service, 264; terrors of children, 554.
Nipples, sore, 63.
Nitre, a solvent of salicylic acid, 164.
Nitrite of amyl in convulsions, 344.
Non-conductivity of fat, 174.
Norristown Insane Asylum, 374.
Northern Georgia, resort for consumptives, 481.
Nussbaum's Jubilee, 176.
Nutrition; effects of injuries, etc., on, 361.
Nutritive enemata, 129.
Nux vomica; as a tonic, 164; in rheumatism, etc., 350.

Obituary Notices—
  Drs. Arthurs, Addison, 352; Bacon, Alvan, Beardsley, L. N., 528; Beck, F. D., 528;

Bedford, Henry M., 220; Bradley, S. M., 44; Coppedge, C. P., 462; Crane, L. M., 528; Davis, F. H., 220; DeYoung, Philip, 242; Emanuel, Manley, 66; Glazier, 560; Lautenbach, B. F., 110; McCay, R. B., 528; McMichael, Josiah, 198; Milbet, H. B., 176; Newton, L.V., 198; Nichols, Isaac A., 560; Row, Herman, 528; Sandford, W. F. 560; Seguin, Edouard, 418; Stewart, G. F., 396; Taylor, Alfred, S. 66; Terhune, G. C., 560; Thomason, T. J., 220, 440; Von Hebra, Prof., 220; Wilcocks, Alex., 462; Wilson, Jos. F., 198; Wythe, W. T., 264.
Obliteration and renewal of brain function, 388.
Obstetrical knowledge in relation to present standard of medical education, 344.
Obstetrics; 516; report on, 334; in eighteenth century, 96.
Obstructed labor, the result of operation for lacerated perineum, 388.
Occlusion, intestinal, constant current in, 282.
Odor of the feet, 364.
Odors of Paris, 462.
Œsophagus; examination of, under chloroform, 125; foreign bodies in, 107.
Oil of eucalyptus, 283.
Olive oil, in large doses for softening, etc., biliary calculi, 365.
Operations for umbilical hernia, 371.
Operative and after treatment; of amputation of supra-vaginal uterus, in fibroma, 212; of facial neuralgia, 553.
Opinions from Canada about venesection, 391.
Opium habit, 440,
Opthalmological notes, 27.
Orchitis, treatment of, 132.
Organisms in water, detection of, 545.
Osteoplastic resection of elbow, 63.
Otological; Congress, 21; and ophthalmological cases, 353.
Our physicians and preachers, 489.
Ovarian tumor complicated with pregnancy, 438.
Ovariotomy; 335; double, 378.
Oxalate of cerium in cholera infantum, 407.
Oxide of zinc in diarrhœa, 281.
Ozæna; 196; syphilitic, 75.

Painful callus, treatment of, 557.
Pamphlet boxes, 439.
Papaw juice, 387.
Paracentesis of the pericardium, 300.
Partial fracture of both bones of forearm, etc., 141.
Patella, fracture of, 270, 372.
Patent medicines in Japan, 87.
Pathological researches on tubercle, etc., 361.
Pathology of lead palsy, 239.
Pauses in respiration, 553.
Peptogenic elixir, 237.
Peptones, 81.
Perforating tuberculosis of roof of skull, 261.
Perfumed carbolic acid, 480.
Pericardium, paracentesis of, 300.
Peripheric measures of temperature, 304.
Persistent priapism, 557.
Perspiration of the feet, 241.
Pertussis; 127; affections of eye from, 248; benzoate of soda in, 369, 538; bromide spray in, 218; cresolene in, 370.
Petechial typhus, salicylate of soda in, 194.
Phacometer, 515.
Pharyngeal catarrh, 336.
Pharyngitis, ergot in, 217.
Phenic acid as an antipyretic, 434.
Philadelphia, sexes, races, and nativities in, 527.
Phimosis, new mode of treating, 195.
Phlebotomy, revival of, 557.
Phobus, Professor, death of, 286.
Phosphate of zinc in diarrhœa, 150.
Phosphorus to make matches, 506.
Phthisis; 1, 12, 133, 165; cause and prevention of, 304; chloral in, 349; curability of, 319; chloride of calcium in, 59; creasote in, 434; pulmonary, 89, 177, 429; purgatives in, 482.
Phthisical cough, treatment of, 349.
Physicians; mortality of, 437; protective register, 440.
Physiological test of intoxicants, 240.
Pills and shot, 330.
Pilocarpin; hypodermically, 408; in anæmia, 18, 194; in diphtheria, 524, 540; in skin disease, 452, 474.
Pirogoff, semi-centennial of, 418.
Placenta prævia, 309.
Plants, digestion in, 435.
Pleurisy, 428.
Pneumonia, digitalis and alcohol in, 281.
Pneumonic; fever, cold pack in, 426; phthisis, 293.
Poisoning; by ergot, 298; by iodide of potassium, 195.
Polli, Professor Giovanni, death of, 368.
Polypoid tumor of the neck, 537.
Polypus of uterus, 272.
Polyuria, 513.
Pomegranate, alkaloids of, 42.
Population of the world, 374.
Possibility of transmission of tuberculosis through milk, 412.
Post-partum hemorrhage, 335; iodine in, 278.
Potency of gonorrhœal virus, 483.
Practice; among the Chinese, 373; of Virginia, 392.
Pregnancy; sick stomach of, 23, 196, 560; the ephelides of, 328.
Prepared blood as an article of food, 436.
Preservation of malar bone in affections on antrum, 331.
Preserving rubber instruments, 330.
Priapism; in leucæmia, 87; persistent, 557.
Professional ethics, 241.
Progressing society, 559.
Prolapsus uteri, new operation for, 304.
Prolonged fasting, 131.
Proper putting to bed prophylactic against puerperal diseases, 464.
Prophylaxis of puerperal convulsions, 393.
Providence, health of, 286.
Prurigo, 556.
Pruritus ani; 122, 217; balsam of Peru in, 150.
Psychiatry, 517.
Ptosis, syphilitic, 73.
Puerperal; convulsions, 385, 419; chloroform in, 233; prophylaxis of, 393; fever, 335; diseases, prophylactic for, 464; in the South, 87.
Pulmonary; disease, altitude in, 320; phthisis, benzoate of soda in, 429.
Purgatives in phthisis, 482.
Purification of sewage, 176.
Pyrosis; 291; glycerine in, 101.

Quality of infection, 435.
Quarantine convention, 549.
Quinine; action of, 195; as inducing labor, 435; hypodermically, 431; in fevers, etc., 355; tasteless, 560.
Quintuple birth, 308.
Quire's nasal and ear curette, 18.

Racinet, Antoine, death of, 330.
Ravages of smallpox, 308.
Recovery from typhlitis, 415.
Rectal; cancer, early incision in, 356; fissure, 122.
Recto-vulval fistula, 90.
Rectum; extirpation of, 507; foreign body in, 85, 414; obscure disease of, 138; stricture of, 386.
Recurrent fibroid, 19.
Reflex psychoses, causes of, 475.
Regulation of body heat, 240.
Relation of menstruation to ovulation, 412.
Remarkable phenomena in injury of brain, 168.
Reminiscences of a visit to Europe, 182.
Removal; of a uterine tumor during labor, 190; of tongue by splitting, 298; of uterine tumors by abdominal section, 343.
Report of seventy-two cases of diphtheria, 425.
Resorcin; some account of, 504; antipyretic properties of, 554.
Respiration; action of salicylic acid, etc., on, 281; with pauses, 553.
Results of marriage with idiots, 504.
Resuscitation of still born, 367.
Reviews and Book Notices.
Arnold—The Sphygmograph in Practice, 213.
Atkinson—Philadelphia Medical Register and Directory, 38.
Bartholow—Treatise on the Practice of Medicine, 409.
Bastian—The Brain as an Organ of Mind, 521.
Beale—On Slight Ailments; Their Nature and Treatment, 456.
Beard—What Constitutes a Discovery in Science, 213.
Bigelow—Practical Utility of Vivisection, 366.
Bockel—Use of Thermo-Cautery in Tracheotomy, 454.
Bridges—Supply and Demand in Relation to Growth, etc., of the Body, 61.
Brinton—Half-Yearly Compendium, 103.
Browne—Medical Hints on the Production and Management of the Singing Voice, 475.
Bulkley—The Skin in Health and Disease, 169.
Byrne—Contributions to Gynæcology, 169.
Chisolm—Myopia in its Various Phases, 324; Optico Ciliary Neurotomy, 213; Salicylate of Sodium in Iritis, 235.
Coles—Intra-Uterine Amputations, 432; Relation of the Placenta to Post-Partum Hemorrhage, 432.
College Announcements, 279.
Coomes—Naso-Pharyngeal Catarrh, 169.
Councilman—Study of Inflammation, as Illustrated by Keratitis, 389.
Duhring—Atlas of Skin Diseases, Part vii, 258; Rise of American Dermatology, 346.
Dulles—What to do First in Accidents, etc., 235.
Dunglison—Practitioner's Reference Book, 61; A New School Physiology, 324.
Dunn—Some Practical Suggestions in Treatment of Diphtheria, 389.
Edwards—How a Person Threatened or Afflicted with Bright's Disease Ought to Live, 500, 555.
Engelman—Dangers Incident to the Simplest Uterine Manipulations and Operations, 454; Time of Conception and Duration of Pregnancy, 83.
Exchanges, 520.
Fothergill—The Practitioner's Handbook of Treatment, 214; Food for the Invalid, the Convalescent, the Dyspeptic, and the Gouty, 555.
Fox—Photographic Illustrations of Skin Diseases, 169; Chrysophanic Acid in Skin Diseases, 543.
Gamgee—Inter-Oceanic Ship Canal and the Yellow Fever, 454.
Gehrung—The Mechanical Treatment of Cystocele and Procidentia, 235.
Gerhart—Therapy of Hot Springs, 147.
Gibney—Notes on Management of Orthopedic Cases, 367; Perinephritis in Children, 367.
Giraud-Teulon—An Elementary Treatise on the Function of Vision and its Anomalies, 555.
Glenn—Contribution to Knowledge of Fracture of Rim of Acetabulum, 388.
Goodell—Elongation of Cervix Uteri, 83.
Goodwillie—Surgical Treatment of Naso-Pharyngeal Catarrh, 454.
Gould—Blank Books, 279.
Gross—Practical Treatise on Tumors of Mammary Gland, 301.
Hamilton—Fracture of the Patella, 214; Biography of Dr. James Aitken Meigs, 555.
Hargis—Ship Origin of Yellow Fever, 147; Its Prevention, 520.
Hardwicke—Medical Education in all Parts of the World, 169.
Heath—Manual of Minor Surgery and Bandaging, 407.
Hewitt—The Pathology, Diagnosis, and Treatment, of Diseases of Women. 235.
Holland—Diet for the Sick, 555.
Hufeland—Art of Prolonging Life, 476.
Jackson, A. R.—Lacerations of the Neck of the Uterus, 213.
Jacobi-White—On the Use of the Cold Pack, followed by Massage, in Anæmia, 543.
Jenks—On Coccygodynia, 38.
Jones—Acts of the Legislature of Louisiana, on Health, etc., 500.
Kelly—Summary of 800 Obstetrical Cases, 235.
Kerlin — Enumeration, Classification, and Causes of Idiocy, 408.
Klein-Smith—Atlas of Histology, 520.
Kingsley—Oral Deformities, 15.
Lawrence—Therapeutic Value of Iodide of Ethyl, 103.
Leonard—Student's Dose-Book and Anatomist Combined, 213.
Legg—Of the Bile, Jaundice, and Bilious Diseases, 456.
Lincoln—School and Industrial Hygiene, 389; Treatise on Therapeutics, Trousseau-Pidoux, 279.

Lindsay & Blakiston—Physician's Visiting List, for 1881, 500.
Lothrop—Medical and Surgical Directory, of Iowa, 1880-81, 214.
Lundy—Diabetic Catarrh, Iritis, and Sympathetic Affection of the Eye, 125; Light in the Public Schools, and School Life in Relation to Vision, 475.
Lutz—Abdominal Surgery, 235.
Mackenzie—Diseases of the Throat and Nose, including the Pharynx, etc, 500.
McIlvaine—Capital Punishment, 408.
Mann—Brain in Health and Disease, 83.
Merrick—Physicians and their Patients, 147.
Oppenheimer—Irritable Bladder in Female, 108; Puerperal Epilepsy and Protracted Gestation, 432.
Ott—Bromide of Ethyl, 38; Physiological Action of Urechitis Suberecta, 432.
Piffard—Cutaneous and Venereal Memoranda, 555.
Pilcher—Indications for Treatment in Fracture of Elbow, 324.
Proceedings of the Philadelphia County Medical Society, 555.
Putzel—Treatise on Common Forms of Functional Disease, 279.
Reed—Hygiene at the Sea-Shore, 346.
Register of Physicians and Midwives in Illinois, 258.
Report on Yellow Fever in U. S. S. Plymouth, 455.
Reynolds—System of Medicine, 83.
Roberts—Compend of Anatomy, 432.
Robinson—Practical Treatise on Nasal Catarrh, 389.
Roosa and Ely—Ophthalmic and Optic Memoranda, 555.
Rumbold—Hygiene and Sanative Measures for Chronic Catarrh of Nose, etc., 346.
Rutherford—Experimental Research in Physiological Action of Drugs on Secretion of Bile, 125.
Seguin—Coincidence of Optic Neuritis and Subacute Transverse Myelitis, 147.
Sims—Pregnancy Vomiting, 235.
Smyth—Interpretations of the Structure and Functions of the Kidney, 300.
Snow—Cause of Syphilitic Degeneration, 388; Twenty-Fifth Annual Report of the Births, Marriages and Deaths in Providence, for 1879, 389.
Sozinskey—The Care and Culture of Children, 432.
Sturgis—Affections of Middle Ear in Syphilis, 258.
Swasey—Hernia in Children, 367.
Tiffany—Malignant Tumor of Upper Jaw, 258.
Transactions; of the Medical Society of the State of Tennessee, 103; of the Medico-Chirurgical Faculty of Maryland, 147; of the American Gynecological Society, 214; of the Indiana State Health Commission, 258; of the Medical Association of Georgia, 300; of the Medical Society of Iowa, 300; of the Medical Association of Mississippi, 300; of the Medical Association of Missouri, 300; of the Medical Society of Arkansas, 300; of the Rhode Island Medical Society, 307; of the Indiana State Medical Society, 324; of the South Carolina Medical Association, 324; of the Tri State Medical Society, 337; of the Southern Illinois Medical Association, 346; of the State Medical Society of Kansas, 367.
Trousseau-Pidoux—Treatise on Therapeutics, 279.
Tuson—A Pharmacopœia, including the Outlines of Materia Medica and Therapeutics, 92.
Vanderveer—Report of Ten Cases of Gastric Ulcer, etc., 432,
Van Harlingen—Syphilitic Muscular Contraction, 61.
Vaughan—Handbook of Chemical Physiology and Pathology, 500.
Walsh—Physicians' Handy Ledger, 555.
Warner—My Winter on the Nile, 555.
Watson—Proper Period for Amputation in Injuries, 83, 408.
Wells—Treatise on the Diseases of the Eye, 367.
Wilson—The Ocean as a Health Resort, 409.
Wylie—Medical Ethics, 83.
Wythe—The Microscopist: a Manual of Microscopy, etc., 346.

MAGAZINES.

American Newspaper Directory, 324.
Atlantic Monthly, 125, 191.
Godey's Lady's Book, 103, 213, 300, 389.
Harper's Bazar, 346.
Harper's Monthly, 192.
International Surgical Record, 125.
Lippincott's Magazine, 103, 192, 388.
North American Review, 213, 300, 389.
Rocky Mountain Medical Review, 147.
The United Service, 83, 191.

Revival of phlebotomy, 557.
Rheumatism; 540, 165; acute, treated by hot soda baths, 173; cold baths in cerebral, 473; nux vomica in, 350; salicine in, 231; salicylate of soda in, 37; subcutaneous injection of water in, 305.
Rigor mortis, ante-mortem, 128.
Ringworm, 14.
Rock and rye, 164.
Rotheln, diagnosis, of, 18, 499.
Row, Herman, death of, 528.
Rubber bandage; in sloughing wounds, 289; in lepra, 396; septicaemia from, 306.
Russia, sanitary work in, 308.

Salicine in rheumatism, 231.
Salicylate of soda; in rheumatism, 37; in petechial typhus, 194.
Salicylated camphor in phagedenic ulcerations, 237.
Salicylic acid; in scarlet fever, 260; on respiration, 281; danger of, 438; nitre, a solvent of, 164; effect on temperature, 414.
Salt, as a prophylactic in diphtheria, 371.
Salubrity of Isthmus of Panama, 154.
Sand bag, in fracture of patella, 270.
Sandford, W. F., death of, 560.
Sanguis bovinus exsiccatus, 130.
Sanitary; Council of Mississippi Valley, 550; work in Russia, 308.
Scabies, ointment for, 348.
Scalp, itching of, 242.

Scarlatina; 485, 539; histo-pathology of, 497; warm baths in, 232; benzoate of soda in, 277; salicylic acid in, 260.
Sciatica; injection of ether in, 328; nux vomica in, 350.
Scirrhus, of the female breast, 474.
Sclerema in adult, 14.
Scleritis; 173; and sclero-keratitis, 36.
Sclerotomy, hyposcleral, 363.
Scrotal tumors, 196.
Seguin, Edouard, death of, 418.
Sense of colors, 436.
Septicæmia from rubber bandage, 306.
Septic embolism of the eye, in puerperal fever, 151.
Septics and antiseptics, 483.
Sewage, purification of, 176.
Shampooing, 505.
Sick headache, 105.
Sickness of pregnancy, 23.
Silicate of soda jackets, 88.
Simple elixir, 88.
Skin disease; 452; pilocarpin in 474.
Skull, fracture of, 14.
Smallpox; antiseptic treatment of, 40; and vaccination, 217; fearful ravages of, 308; in Denmark, 170; in Havana, 131; in Norway, 120.
Snake bite, cure for, 132.
Soda-baths in acute rheumatism, 173.
Sodomy causing disease, 274.
Some; effects of medical legislation, 308; important uses of amyl nitrite, 554.
South America as a health resort for consumptives, 282.
Spanking and flogging as therapeutic measures, 438.
Specific agent of typhoid fever, 502.
Spermatozoa, structure of, 151.
Spinal cord, diseases of the, 529.
Spleen, abscess of, 211.
Starvation heroes, 330.
Stewart, G. P., death of, 396.
Stigmata of maize in urinary complaints, 145.
Still-born child, resuscitation of a, 307.
St. Mary's Hospital, 506.
Stomach, diagnosis of cancer in, 107.
Stone in bladder; difficult case of, 105; estimation of size of, 453.
Strangulation of intestine, etc., simulating aneurism, 262.
Stricture of rectum caused by syphilis, 386.
Structure of spermatoza, 151.
Strychnia poisoning; 86; 416; chloral in, 415; in exhumed bodies, 191.
Studies in inebriety, 287.
Sub-astragaloid amputation of the foot, 470.
Subcutaneous; division of nerve for pain, 364; injection of ether in sciatica, 328; injection of water in rheumatism, 305.
Sub-phrenic pyopneumothorax, and abscess, 60.
Suction operation for cataract, 463.
Sudden death in typhoid, 452.
Sugar in urine, test for, 372.
Suicides and drunkenness, 86.
Summer diseases of children, 111, 155.
Superfœtation, 86.
Surgical; activity in treatment of head injuries, 203; operation for neuralgia, 553.
Suture of divided nerves, 322.
Sympathetic; nervous cough of pregnancy, 217; ophthalmia, conservative treatment of, 546.
Syphilis; 491; causing stricture of rectum, 386; diagnosis of, 184; deafness from, 510; prognosis and treatment of primary, 41; and laryngeal phthisis, diagnosis between, 37.
Syphilitic; disease of blood vessels, 277; epilepsy, 233; ptosis, 73; ozæna, 75; ulceration of rectum from sodomy, 274.

Tænia, remedies for, 369.
Talck, Professor, death of, 286.
Tale of two cities, 559.
Tanner's fast, 110, 132, 154.
Tanner, distanced, 417.
Tartar emetic, antipathic effects of, 86.
Tasteless; cod-liver oil, 328; quinine, 560.
Taste of bromide of potassium, to disguise, 303.
Tattooing, 440.
Tax on privies and sewers, 220.
Teeth, care of, 431.
Temperature; action of collodion on, 195; extremes of, 413; effects of salicylic acid on, 414; peripheric measurement of, 304.
Terhune, G. C., death of, 560.
Tetanus; chloroform in, 172; treated by stretching the median nerve, 234; traumatic, 540.
Texas or splenic fever, 460.
The; Columbia Hospital for Women, 333; quinia mania, 341.
Therapeutic; "boom" and unscientific advertising, 465; use of pilocarpin in skin diseases, 474; uses of iodoform, 473.
Therapeutics of chronic metritis, 451.
Thomason, T. J., death of, 440.
Thoracic, aneurism, new physical sign of, 556.
Throat lozenge, 290.
Thymic acid for diphtheria, 150.
Tinea; capitis, 439; circinata, 308; tonsurans, 82.
Tobacco; influence on health, 144; smoke, 152.
Tongue, removal of, 298.
Tonsillitis, 292.
Tracheotomy superseded, 348.
Transfusion; indications for, 227; of blood, 322.
Transposition of viscera, 276.
Traumatic tetanus, 540.
Treatment; of diffuse phlegmon, 474; of pain from nerve injury by division of nerve, 364; of chronic cystitis, 547; of painful callus, 557.
Trembles, 416.
Trephine, improvement in, 175.
Trichinosis, 496; in American pork, 496.
Tricycle, 506.
Triple, ovary, 436.
Tubercle, researches on, 361.
Tuberculosis; as an infectious disease, 172; of the heart, 195; transmission of, by milk, 412.
Tuberculous inflammation of internal coat of vessels, 17.
Tulipine, action of, 556.
Tumors, scrotal, 106.
Turkish Bath in hay asthma, 372.
Two new anæsthetics, 504.
Twin pregnancy with complication, 404.
Typhlitis, recovery from, 415.
Typhoid; causes of, 481; fever; 166; etiology of, 221; iodide of potassium in, 345; specific agent of, 502; sudden death in, 452.

Ulceration of bowels, 123.
Ulcers, 260.
Umbilical; cord, new mode of dressing, 393; hernia, operations for, 371.
Uræmic convulsions, pilocarpin in, 194.
Urethral chancroid, 146.
Urine; continence of, 303; unchanged diabetic, 548.
Urticaria, nettle tea in, 414.
Uterine; fibroid removed with Thomas' scoop, 80; fibroids and myomata, 305; hemostatics, 342; mucous membrane during menstruation, 129.
Uterus, polypus of, 272.
Uveal tract, diseases of, 238.

Vaccinal eruptions, 194, 547.
Vaccination, 365, 462.
Varicocele, 504.
Varieties of vaccinal eruptions, 547.
Vegetable diet for children, 371.
Venesection; in Canada, 391; in hæmophilia, 453.
Vertebræ, fracture of, 447.
Vesical; calculus, 337; catarrh, bromide of potash in, 412.
Vesico-vaginal fistula, 100.
Veterinary medicine, 484.
Virginia, medical practice in, 392.
Viscera, transposition of, 276.
Visit to Europe, 250.
Vivisection in Germany, 21.
Vocal cords, flaying the, 398.
Vomiting in pregnancy, 560.

Walnut Hill Asylum, 559.
Warburg, Dr., poverty of, 330.
Warm baths in scarlatina, 232.
Warning to travelers in Europe, 197.
Watching the pulse under chloroform, 211.
Water, detection of organisms in, 545.
Way of transgressors, 559.
Weak eyes, 53.
Weight, loss of, 418.
What to take for a cold, 506.
Whipping in hysteria, 195.
Why we eat oysters raw, 154.
Wilcocks, Alexander, death of, 462.
Williams, William, death of, 330.
Wilms, Dr., death of, 395.
Wilson, Joseph P., death of, 196.
Womb, fibroid of, 512.
Women delegates excluded from the international congress, 176.
Word of interest to every subscriber, 523.
World, population of, 374.
Worms in children, 413.
Wounds, dressing of 517.
Wrist, dislocation at the, 191.
Wythe, W. T., death of, 264.

Xylotherapy, 305, 437.

Yearly revenue and expenses of the Paris board of charity, 527.
Yellow fever at Key West, 374, 461.

SERIAL

P
Med
M
v.43

Medical and surgical reporter
(Philadelphia)

GERSTS